

18
No. 98-536

Supreme Court, U.S.

FILED

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In The
Supreme Court of the United States
October Term, 1998

TOMMY OLMSTEAD, et al.,

v. *Petitioners,*

L.C. and E.W., each by JONATHAN ZIMRING
as guardian ad litem and next friend,

Respondents.

On Writ Of Certiorari To The United States Court
Of Appeals For The Eleventh Circuit

JOINT APPENDIX

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Petition For Certiorari Filed September 29, 1998
Certiorari Granted December 14, 1998

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RELEVANT DOCKET ENTRIES

L.C. et al. v. Olmstead et al., United States District Court for the Northern District of Georgia, Civil Action No. 1:95-CV-1210-MHS

5/11/95 COMPLAINT.

6/2/95 ANSWER.

6/16/95 MOTION by E.W. to intervene.

2/20/96 RESPONSE TO Intervenor's Complaint.

8/20/96 PLAINTIFFS' MOTION For Summary Judgment.

8/22/96 DEFENDANTS' MOTION For Summary Judgment.

3/26/97 ORDER AND JUDGMENT.

4/17/97 DEFENDANTS' MOTION to Stay Judgment.

5/22/97 ORDER denying Defendants' Motion to Stay Judgment.

IN THE UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF GEORGIA
ATLANTA DIVISION

L.C., by JONATHAN ZIMRING)	
as guardian ad litem and next)	
friend,)	
Plaintiff,)	CIVIL ACTION
v.)	FILE NO.
)	1 95-CV-1210-
)	<u>MHS</u>
TOMMY OLMSTEAD,)	
Commissioner of the Department)	
of Human Resources; RICHARD)	
FIELDS, Superintendent of)	
Georgia Regional Hospital at)	
Atlanta; and ERNESTINE)	
PITTMAN, Executive Director of)	
the Fulton County Regional)	
Board, all in their official)	
capacities,)	
Defendants.)	

COMPLAINT

(Filed May 11, 1995)

I.

INTRODUCTION

1.

Plaintiff, L.C., a 27 year old mentally retarded person, brings this action challenging her continued confinement at Georgia Regional Hospital at Atlanta ("GRH-A"). GRH-A is a state hospital for persons suffering from acute psychiatric illnesses. GRH-A is *not* a hospital for the habilitation of persons with mental retardation. Although

Plaintiff was confined in May, 1992, for treatment of schizophrenia, she no longer requires inpatient psychiatric treatment.

2.

Despite the professional judgment of her psychiatric treatment team that L. C. no longer requires confinement for treatment of her mental illness and needs community residential and habilitation services, Defendants have continued to forcibly confine Plaintiff to GRH-A.

3.

Because Plaintiff's mental illness no longer serves as a basis for her involuntary hospitalization, Plaintiff's continued confinement is clearly based solely on her disability, mental retardation. This constitutes illegal discrimination against the disabled.

4.

Because Defendants have subjected Plaintiff to prolonged and unnecessary confinement in a mental hospital and thus deprived her of minimal habilitation in an appropriate setting, her condition has regressed, she has lost basic self-care and adaptive living skills, and she has failed to maintain or develop other skills fundamental to her ability to function outside of an institution.

4

5.

Defendants have therefore violated Plaintiff's constitutional and statutory rights to freedom from undue restraint, minimally adequate treatment, freedom from illegal discrimination, and placement in the most integrated setting appropriate to her needs under the Fourteenth Amendment to the U.S. Constitution, the Americans with Disabilities Act, and 42 U.S.C. § 1983. Thus, Plaintiff seeks immediate declaratory and injunctive relief requiring Defendants to release her from GRH-A, place her in the most integrated setting appropriate to her needs, and provide her with the appropriate treatment and services.

II.

JURISDICTION

6.

This Court has subject matter jurisdiction over this action pursuant to 28 U.S.C. §§ 1331 and 1343 and 42 U.S.C. § 12133 in that this is an action arising under the Americans with Disabilities Act, the Fourteenth Amendment to the United States Constitution, and 42 U.S.C. § 1983.

7.

This Court has jurisdiction to award declaratory and injunctive relief pursuant to 28 U.S.C. §§ 2201 and 2202 and 42 U.S.C. § 1983.

5

8.

Venue is proper under 28 U.S.C. § 1391.

III.

PARTIES

9.

Plaintiff, L.C. , is twenty-seven years old and has a diagnosis of mental retardation and schizophrenia or schizoaffective disorder. Her psychiatric symptoms have been controlled adequately for over two years and she does not require inpatient psychiatric hospitalization. In spite of the evaluations and professional judgments of L.C.'s treatment staff that Plaintiff does not require hospitalization but needs community residential and habilitation services, Defendants have refused to provide such services. Thus, Plaintiff remains hospitalized at GRH-A, a hospital for persons with active mental illness, solely by reason of her mental retardation with little or no provision of habilitation that is related to her mental retardation. Plaintiff is a resident of Fulton County, Georgia.

10.

Defendant Tommy Olmstead is the Commissioner of the Department of Human Resources ("DHR") and is responsible for the operation of GRH-A, for the protection of the rights of persons confined to GRH-A, and for the overall provision of services to persons suffering from mental retardation and mental illness in the State of Georgia.

11.

Defendant Richard Fields is the Superintendent of GRH-A, located in DeKalb County, Georgia. As such, he is responsible for the operation of GRH-A, for the treatment of persons confined to GRH-A, and for the protection of rights of persons confined to GRH-A.

12.

Defendant Ernestine Pittman is the Executive Director of the Fulton County Regional Board (the "Board") and is responsible for the provision of mental health and mental retardation services, including community care and placement, for all residents of Fulton County.

IV.

STATUTORY AND CONSTITUTIONAL FRAMEWORKA. The Americans with Disabilities Act

13.

In 1990, Congress enacted the Americans with Disabilities Act ("ADA"), 42 U.S.C. §§ 12101 *et seq.* Title II of that Act provides as follows:

. . . [N]o qualified individual with a disability, shall by reason of such disability, be excluded from participation in or be denied the benefits of the services, programs, or activities of a public entity, or be subjected to discrimination by any such entity.

42 U.S.C. § 12132.

14.

In passing this Act, Congress explicitly stated that the purposes of the ADA were:

- (a) *to provide a clear and comprehensive national mandate for the elimination of discrimination against individuals with disabilities;*
- (b) *to invoke the sweep of congressional authority, including the power to enforce the fourteenth amendment and to regulate commerce, in order to address the major areas of discrimination faced day-to-day by people with disabilities.*

42 U.S.C. § 12101(b)(1) & (4). (Emphasis added.)

15.

In defining this purpose, Congress made the following significant findings which are especially relevant to this case:

- (a) *historically, society has tended to isolate and segregate individuals with disabilities, and, despite some improvements, such forms of discrimination against individuals with disabilities continue to be a serious and pervasive social problem;*
- (b) *discrimination against individuals with disabilities persists in such critical areas as . . . institutionalization, health services, . . . and access to public services;*
- (c) *. . . individuals who have experienced discrimination on the basis of disability have often had no legal recourse to redress such discrimination;*

- (d) individuals with disabilities continually encounter various forms of discrimination, including . . . failure to make modifications to existing facilities and practices, . . . *segregation*, and relegation to lesser services. . . . ;
- (e) the Nation's proper goals regarding individuals with disabilities are to assure . . . *independent living*

42 U.S.C. § 12101(a)(2), (3), (4), (5), and (8). (Emphasis added.)

16.

The legislative history of the ADA comports with the statutory findings that unnecessary institutionalization and segregation is a destructive practice that Congress sought to end. This point is supported most eloquently by the testimony of Senator Lowell Weicker, the original sponsor of the ADA and former Chair of the Senate Subcommittee on the Handicapped:

For years, this country has maintained a public policy of protectionism toward people with disabilities. *We have created monoliths of isolated care in institutions and in segregated educational settings. It is that isolation and segregation that has become the basis of the discrimination faced by many disabled people today. Separate is not equal. It was not for black[s]; it is not for the disabled.*

ADA Hearing before the Senate Comm. on Labor and Human Resources and Subcomm. on the Handicapped, 101st Cong., 1st Sess. 215 (1989) (Emphasis added.)

17.

In keeping with the statutory language and legislative history, federal regulations implementing the ADA provide that:

A public entity shall administer services, programs, and activities *in the most integrated setting appropriate* to the needs of qualified individuals with disabilities.

28 C.F.R. § 35.130(d) (1993) (Emphasis added.)

B. The Fourteenth Amendment

18.

The Fourteenth Amendment to the U.S. Constitution provides in pertinent part:

. . . [N]or shall any state deprive any person of life, liberty, or property, without due process of law. . . .

C. Georgia Mental Health Code

19.

Georgia's Mental Health Code and implementing regulations provide that:

Each client in a facility and each person receiving services for mental retardation shall receive habilitation that is suited to his needs and is the least restrictive appropriate habilitation.

O.C.G.A. § 37-4-122(a); Chapter 290-4-6-02(1)(A), Ga. Admin. Code.

State law further provides with regard to the habilitation of persons with mental retardation:

It is the policy of the state that the least restrictive alternative placement be secured for every client at every stage of his habilitation. It shall be the duty of the facility to assist the client in securing placement in noninstitutional community facilities and programs.

O.C.G.A. § 37-4-121.

There are identical provisions of state law requiring individualized, least restrictive appropriate treatment and assistance in securing community placement for mentally ill persons. *See* O.C.G.A. § 37-3-162(a) and O.C.G.A. § 37-3-161.

A person receiving court-ordered services for mental retardation is entitled to an individual program plan for appropriate care, training, education, habilitation and other needed specialized services "written in behavioral terms" and containing, among other requirements, "a description of intermediate and long-range habilitation goals and a projected time-table for their attainment" and "an explanation of criteria for acceptance or rejection of alternative environments for habilitation." *See* O.C.G.A. § 37-4-40(c); O.C.G.A. § 37-4-2(9); Chapter 290-4-6-.01(4)(i), Ga. Admin. Code.

There are identical provisions of state law requiring the development of an individualized service plan for a mentally ill person "specifically tailored to the individual's treatment needs," and including among other requirements "identification of the types of professional personnel who will carry out the treatment." *See* O.C.G.A. § 37-3-64(c); O.C.G.A. § 37-3-1(9); Chapter 290-4-6.01(4)(i), Ga. Admin. Code.

Amendments to the state law, effective July 1, 1994, provide that the state office for mental health and mental retardation services:

... is authorized to move funds to and between community and institutional programs based on need. . . .

O.C.G.A. § 37-2-5-1(c)(3). Those amendments provide further that:

The State of Georgia recognizes its responsibility for its citizens who are mentally ill or mentally retarded . . . to meet their needs through a coordinated system of community facilities, programs, and services.

O.C.G.A. § 37-2-1(a).

Finally, the state law, "Community Services for the Mentally Retarded", mandates community-based services when "deemed reasonably necessary by the Department (of Human Resources) to provide for education, training,

rehabilitation, and care of mentally retarded individuals."
See O.C.G.A. § 37-5-1 *et seq.*

V.

FACTUAL ALLEGATIONS

25.

L.C. is a 27-year old African-American woman with mental retardation. In addition to mental retardation, she also has a diagnosis of schizophrenia or schizoaffective disorder. She is a friendly person with a beautiful smile, genuine artistic talent, and a remarkable enthusiasm for writing words on paper.

26.

L.C. is disabled.

27.

L.C. has consistently been diagnosed with mild or moderate mental retardation; she has only very elementary ability to read and write a few words and a very limited ability to understand abstract concepts.

28.

L.C. is currently residing on an adult psychiatric unit at Georgia Regional Hospital - Atlanta (GRH-A), a facility owned and operated by the State of Georgia; she has lived most of her life since age 14 at this facility and other institutions.

29.

GRH-A is a facility licensed and staffed to provide care and treatment for persons with psychiatric illnesses. Its programs are primarily designed to stabilize individuals during the acute phase of a mental illness so that ongoing mental health treatment can then be continued in the community on an outpatient basis.

30.

The average length of stay for a patient at GRH-A is 21 days, but L.C. has lived there for more than three years.

31.

GRH-A is a large institution with about 300 patients, divided into various units or wards; each of the adult psychiatric units has between 30 and 60 patients.

32.

The unit where L.C. lives is called the "treatment unit"; it is a longer term unit for patients who remain hospitalized for several weeks or months. The average number of patients on the unit is 65.

33.

In 1991, L.C. was placed in a community program for persons with mental retardation arranged by a non-profit

organization, Project Rescue, after many years of inappropriate psychiatric institutionalization at GRH-A from 1984 through 1991.

34.

L.C. lived quite successfully in that program for about one year.

35.

In May 1992, L.C. experienced a period of stress apparently related to a conflict with staff in the community program; she began expressing a desire to be hospitalized and began exhibiting some aggressive and psychotic behavior.

36.

In May 1992, L.C. was hospitalized at GRH-A for treatment of her mental illness.

37.

After L.C. was hospitalized, another person moved into her community residential "slot".

38.

The specific purpose of her admission to the hospital was to stabilize her psychiatric symptoms so that she could be returned to a community setting as soon as

possible. At that time, L.C.'s hospitalization was intended to be a brief period of inpatient treatment.

39.

At the time of her hospitalization, the hospital developed a treatment plan which focused on the stabilization of her mental illness. As early as June, 1993, L.C.'s treating physician at GRH-A concluded that the primary psychiatric treatment goal had been met.

40.

Once L.C.'s condition had stabilized, she no longer needed to be confined in an institution; she could have functioned from that point in a more integrated, community setting with adequate supervision.

41.

As early as November, 1992, staff began to regularly note that L.C.'s condition remains the same or "unchanged."

42.

In January, 1993, a social worker contacted "mental retardation services" for placement but there is no record of any response.

16

43.

In March, 1993, L.C.'s physician expressed his belief that because "she cannot live in the community without structure," he must "file for commitment."

44.

In April, 1993, L.C.'s physician noted that "placement remains a problem" and the team nurse stated that she is "stable awaiting placement."

45.

In July, 1993, L.C.'s physician was of the opinion that her need for "constant structure" was the "main problem preventing from placing her" and her nurse was of the opinion that she "remains the same, has reached maximum level of functioning. Placement is primary problem."

46.

In August, 1993, L.C.'s physician stated his belief that L.C.'s need for "constant reminder to keep her face clean" was a significant barrier to placement.

47.

In September, 1993, L.C.'s social worker told her that he will assist her in finding a "personal care home" placement.

17

48.

Up to the present time, Defendants have completely failed to place L.C. in an appropriate community residential setting outside the hospital.

49.

Once L.C.'s psychiatric condition had stabilized, her primary treatment and habilitation needs were related to her mental retardation. These needs could not be and were not adequately addressed at GRH-A.

50.

During the three years that L.C. has been confined in a mental hospital, no individualized habilitation program has been designed or implemented for her by qualified mental retardation professionals with training or experience in the habilitation of mentally retarded persons.

51.

For the first two years of L.C.'s confinement at GRH-A and for much of the time during her previous years in the institution, she would sit around in the day room areas doing nothing. From May, 1992, through August, 1994, her primary activities consisted of several hours a day in a pre-vocational program on the hospital grounds, a hygiene group and a communication group, each of which met for a total of two or three hours each week.

52.

Because L.C. is in a mental hospital, the policies, standards, and regulations applicable to the appropriate habilitation of mentally retarded persons in state, federal, and other publicly funded programs, such as those that govern the use of restraint, seclusion, medication, and the development and implementation of habilitation plans, have not been followed by her treating professionals at GRH-A.

53.

Upon information and belief, none of the professionals on L.C.'s treatment team at GRH-A are qualified mental retardation professionals with experience or training in the habilitation of mentally retarded persons nor has L.C. been evaluated by any such professional on the hospital staff during her three years at the hospital.

54.

L.C.'s hospital record reveals many instances of the staff's inappropriate responses to L.C., the absence of a consistent, professional approach to her behavioral problems, and a reliance by staff on psychotropic drugs to manage behavior.

55.

The record also reveals that the hospital staff was and is without basic information regarding both the capacity of mentally retarded persons to live in the community

with proper support and the capability of mental retardation community programs to deal with L.C.'s behavioral deficits.

56.

For example, L.C. was told that she cannot work unless she "keeps herself clean" and staff repeatedly commented that she takes many baths but does not wash properly. At the same time, her treatment team decided that she must show an ability to work successfully for an extended period of time before she can be considered for discharge. No professionally designed, consistent behavior management plan was designed to help L.C. learn how to keep clean.

57.

Hospital staff often control L.C. with the administration of sedatives or psychotropic drugs when she is loud and disruptive, but she has never been disruptive at the community day program which she began in August, 1994.

58.

In the professional judgment of two mental retardation assessment teams in 1986 and 1988 as well as the two GRH-A treating psychiatrists responsible for L.C.'s care, as well as the nurses and social workers that have been on her treatment team since May, 1992, long-term psychiatric hospitalization is inappropriate, unnecessarily restrictive, and does not meet her individual needs.

59.

In the professional judgment of L.C.'s treatment staff and an independent clinical psychologist, her long-term treatment and habilitation must be conducted in a less restrictive and more appropriate setting in the community and not on an inpatient psychiatric ward.

60.

L.C.'s confinement on a locked ward in a mental hospital is a degree of restraint on her freedom which is inconsistent with the professional judgment of mental retardation evaluators and her hospital treatment staff concerning her appropriate treatment.

61.

Despite the professional judgment of L.C.'s two treating physicians at GRH-A and other members of her treatment team at the hospital that L.C. should not continue to be confined in a mental hospital, it was and is the understanding and belief of all staff involved with her care that no alternative community residential placements are available and that, for this reason, L.C.'s only option is to remain in the hospital.

62.

Confinement in a mental hospital is detrimental to L.C. She pleads on a daily, sometimes hourly, basis to be released and expresses great sadness, hopelessness, and frustration that another place to live cannot be located.

This level of anxiety about her situation and uncertainty about her future interferes with her ability to function.

63.

During the past three years, while institutionalized, L.C. has lost basic self-care skills, such as the ability to use the bathroom on her own without constant reminders.

64.

L.C.'s mental condition has remained essentially unchanged during the past three years of confinement but her social skills, her self-care skills, her adaptive abilities, and her overall capacity to function in society have diminished.

65.

In addition to the past three years, L.C.'s many previous years of inappropriate institutional confinement during the period from 1985 through 1991 are a primary factor in her present need for a structured and supervised community placement to assist her in the transition to more independence.

66.

Since August, 1994, L.C. has participated in a community-based day program away from the hospital. In this environment, she has begun to show progress in areas of functioning, such as social skills, activities of

daily living, and the ability to express and control emotion, which had remained essentially unchanged since her admission to GRH-A in 1992.

67.

Minimal habilitation for L.C. would consist of specialized programs, training, and behavior management programs designed by mental retardation professionals to meet her individual needs.

68.

The minimally adequate setting for L.C.'s long-term habilitation is placement in the community.

69.

During the three years that L.C. has resided in the treatment unit at GRH-A, she has lived in an environment that is completely isolated and segregated from society; other than members of the hospital staff, she has virtually no contact with persons other than severely mentally ill persons in the acute phase of their illness.

70.

Because L.C. lives in an institution with mentally ill individuals, she has no opportunity to interact with non-disabled persons in daily activities and no opportunity to learn and maintain skills that would enhance her ability to become more integrated into society, such as riding a

bus, shopping, cooking, and doing simple housekeeping tasks.

71.

The state, through its county, regional, and contracted private providers operates a supervised, community-based residential program for persons with mental retardation. The cost of placement in a such a program is substantially less expensive than the cost of institutional care.

72.

The hospital administration, the state office for mental retardation services, as well as the county and regional mental retardation programs, have been aware of L.C.'s need for community services through many informal and formal efforts to secure these services.

73.

Because L.C. is both mentally retarded and mentally ill, she has received lower priority for community placement than persons whose diagnosis is exclusively mental retardation.

74.

There are existing vocational, habilitative, social, and residential programs in the community operated fully or in part by the Defendants with the necessary experience,

qualified staff, and the appropriate support and supervision to provide L.C. with the minimal habilitation that she needs in a much more integrated setting than her present institutional placement.

75.

One of these programs, TOPS, has assessed L.C. and would be willing to place her in a supervised home or apartment setting through the "personal support" medicaid waiver program if the state or county would provide the requisite "match" to secure the federal medicaid funds for implementation of an appropriate community habilitation program for L.C.

76.

The state and county have established many such placements with similar arrangements for other mentally retarded persons.

77.

During the period that L.C. has been confined at GRH-A, she received a \$14,000.00 lump sum Social Security payment in October, 1992; she also receives a regular monthly Social Security disability payment of \$380.00.

78.

The hospital, when informed of the lump sum payment, completed the necessary forms to become L.C.'s

payee so that the hospital would have the authority to spend the money for L.C.'s benefit.

79.

After becoming the payee for L.C.'s Social Security benefits, the hospital then initiated a second procedure pursuant to state law which would permit the application of the lump sum and monthly benefits to the cost of L.C.'s care at the hospital.

80.

These actions of the hospital resulted in the application of all of L.C.'s funds toward the cost of her institutional care rather than toward the cost of a community alternative, with the exception of a small monthly allowance to purchase cigarettes and a \$5,000.00 burial fund.

81.

Upon information and belief, the hospital failed to submit a claim for available medicare insurance coverage on L.C.'s behalf until recently when Plaintiff's attorney raised concerns about the hospital's application of all the funds available to L.C. for alternative placement to the cost of her institutional care.

82.

L.C. had a right to a hearing in the proceeding where the hospital became the payee for her Social Security

benefits and in the proceeding which resulted in the application of essentially all of her funds to her cost of care.

83.

Although notices regarding the procedures for requesting these hearings were received by the hospital, L.C. was not made aware of these notices in either proceeding and no hearings were requested or conducted on her behalf.

84.

At all times relevant to this Complaint, Defendants have acted under color of state law.

85.

Defendants' actions have caused and are continuing to cause Plaintiff irreparable harm.

VI.

CLAIMS FOR RELIEF

COUNT ONE - ADA

86.

Defendants have discriminated and are discriminating against Plaintiff on the basis of her disability in violation of Title II of the ADA, 42 U.S.C. § 12131 *et seq.* and the ADA's implementing regulations at 28 C.F.R. § 35.130.

COUNT TWO - FREEDOM FROM UNDUE RESTRAINT

87.

Defendants have violated and are violating Plaintiff's right to be free from undue restraint, guaranteed to her by the Due Process Clause of the Fourteenth Amendment.

COUNT THREE - RIGHT TO TREATMENT

88.

Defendants have failed and are failing to provide Plaintiff with treatment that is minimally adequate, in violation of her rights under the Due Process Clause of the Fourteenth Amendment.

COUNT FOUR - REGRESSION

89.

Defendants have failed and are failing to provide Plaintiff with the treatment and training that is necessary to prevent her pre-existing skills from deteriorating as a result of her institutionalization, in violation of her rights under the Due Process Clause of the Fourteenth Amendment.

COUNT FIVE

TREATMENT RELATED TO
PURPOSE OF CONFINEMENT

90.

Defendants have failed and are failing to provide Plaintiff with conditions of confinement that are reasonably related to the purpose of her confinement, in violation

of her rights under the Due Process Clause of the Fourteenth Amendment.

COUNT SIX
DEPRIVATION OF STATE-CREATED
LIBERTY INTEREST

91.

Defendants have failed and are failing to provide Plaintiff with individualized treatment in the least restrictive environment or otherwise provide Plaintiff with proper treatment mandated by state law. Defendants, failure to provide such treatment violates Plaintiff's state-created liberty interest under the Due Process Clause of the Fourteenth Amendment.

VII.
PRAYER FOR RELIEF

92.

WHEREFORE, Plaintiff requests that this Court:

- A. Assume jurisdiction of this case;
- B. Declare that Defendants' actions and failures to act as described above violate the ADA, the Fourteenth Amendment to the U.S. Constitution, and 42 U.S.C. § 1983;
- C. Preliminarily and permanently enjoin the Defendants from further violating Plaintiff's rights under the ADA, the Fourteenth Amendment, and 42 U.S.C. § 1983 and specifically requiring them to:
 1. Cease discriminating against Plaintiff on the basis of her disability;

2. Provide Plaintiff with appropriate habilitation, training services, and other treatment that comport with professional standards for the treatment of persons suffering from mental retardation and mental illness including, but not limited to, release from GRH-A into a community care residential program;
 3. Require that all habilitation, training services, and other treatment be provided by professionals qualified by education, training, and experience to provide such services;
 4. Provide Plaintiff individualized treatment in the least restrictive environment with the ultimate goal of integrating Plaintiff into the mainstream of society;
 5. Provide Plaintiff minimally adequate treatment to prevent deterioration of her pre-existing skills and that is related to the purpose of her confinement;
 6. Cease unduly restraining Plaintiff's freedom of movement.
- D. Award Plaintiff costs and attorney's fees; and
- E. Award any other relief the Court deems just and equitable.

/s/ Susan C. Jamieson
SUSAN C. JAMIESON
Georgia Bar No. 389408
340 W. Ponce de Leon
Avenue
Decatur, Georgia 30030
(404) 377-0701

/s/ Steven D. Caley
STEVEN D. CALEY
Georgia Bar No. 102866
151 Spring Street
Atlanta, Georgia
30303-2097
(404) 614-3926

Attorneys for Plaintiff

Dated: May 11, 1995.

IN THE UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF GEORGIA
ATLANTA DIVISION

L.C., by JONATHAN ZIMRING as)
guardian ad litem and next friend,)

Plaintiff,)

v.)

TOMMY OLMSTEAD, Director of)
the Department of Human)
Resources; RICHARD FIELDS,)
Superintendent of Georgia)
Regional Hospital at Atlanta; and)
ERNESTINE PITTMAN, Executive)
Director of the Fulton County)
Regional Board, all in their official)
capacities,)

Defendants.)

CIVIL ACTION

FILE NO.

1: 95-CV-1210 MHS

AFFIDAVIT OF M. CECILIA KIMBLE, Ph.D

* * *

28.

The institutional environment, peopled by individuals in crisis and acute psychotic states, is chaotic and complex. Long-term confinement under such conditions for an individual such as L.C., whose ability to comprehend her environment is at an extremely low level, is likely to result in regression or to the development of additional maladaptive modes of behavior.

29.

The development of L.C.'s inappropriate urinary habits and subsequent urinary incontinence while institutionalized is suggestive of the acquisition of maladaptive and regressive behaviors, respectively.

* * *

Progress Notes
Patient Identification
L.C.

Date: 11/4/93

Time: 3:10 pm

Disc.: NSG.

Notes: A - Pt. stable medically & physically, P. Maintain
highest level of functioning until placement.
Ahstahes Rn

DATE 11/6/93 TIME 10:30pm

SIGNATURE /s/ SNSTOKES, RN

* * *

IN THE UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF GEORGIA
ATLANTA DIVISION

[Caption Omitted In Printing]

AFFIDAVIT

Personally appeared, Randy Allen Brazee, the undersigned affiant, who being duly sworn says:

1.

This affidavit is given on the basis of the affiant having personal knowledge pertaining to the above-styled action and the facts stated herein.

2.

I am an adult, competent, and suffer from no disability which affects my capacity to make this affidavit as accurate as possible.

3.

My name is Randy Brazee. I graduated in 1990 from the University of Wisconsin with a BS in social work and psychology.

4.

From August 16, 1993, until January 2, 1995, I was employed by Georgia Regional Hospital - Atlanta (GRH-A), a state psychiatric hospital, as an inpatient social worker and case manager for adults with severe mental illness, a position which included counseling to achieve

treatment goals, development of aftercare plans, intensive case management, and linkage of patients with appropriate community housing and other resources.

5.

Since January, 1995, I have been employed by TOPS (Tailored Options for Person-Centered Support) as a case manager.

6.

TOPS is a private agency that provides a full range of personalized options for residential, day habilitation, supported employment, and personal assistance services for persons with mental retardation.

7.

The unit where I worked at GRH-A is referred to as the "treatment unit." It is a single, large building divided into separate sleeping areas for men, women, or "coed" with a typical patient census of about 65 patients. Most patients stayed for a short time until the acute symptoms of psychiatric illnesses had been stabilized.

8.

The treatment unit is not designed or staffed for the habilitation or specialized needs of persons with mental retardation; there is a unit at the hospital where persons with mental retardation reside called the "Developmental Learning Center."

9.

When I first began to work at GRH-A in August, 1993, I noted a young female patient, L.C., whose condition remained the same day after day and week after week. She appeared to be stable and simply living at the hospital.

10.

When the social worker that had been assigned to L.C. resigned, I asked that she be assigned to my caseload; I was L.C.'s social worker from about November, 1993, until January, 1995, when I left GRH-A to begin my present job.

11.

As L.C.'s social worker, I was aware of her physician's opinion that she should not be hospitalized at all, that her psychiatric symptoms had been stabilized, and that she remained hospitalized solely because there were no alternative placement options.

12.

Because of the opinion of Dr. Amin and the consensus of L.C.'s treatment team that hospitalization was no longer clinically necessary or appropriate for her, my responsibility was to find alternative placement.

13.

Since L.C.'s psychiatric symptoms were stable, she could function in the community with appropriate day program activities, psychiatric oversight, and residential services designed to meet her individual needs as an adult with mental retardation.

14.

For the first ten months (from November, 1993, through July, 1994), that L.C. was assigned to my case-load, she continued to live in essentially the same situation that I had observed since I began to work on the treatment unit.

15.

During this period, she did very little during the day except sit or walk around the locked "day room" on the ward. The activity that seemed to be the most important to her during this time was smoking cigarettes.

16.

I recall that she participated in activities for just a few hours a day; a pre-vocational program, an evening "hygiene group," and a "communication skills" group.

17.

The pre-vocational program involved routine, repetitive tasks, such as putting caps on bottles. L.C. appeared to enjoy the opportunity to participate in this program,

was successful at most of the assigned tasks, and was highly motivated by the small amount of money that she was able to earn in the program. L.C. would attend the program two to four times a week for about one and one-half hours.

18.

The "communication skills" program was a 4-6 week program to assist hospitalized patients with simple conversational and social skills, such as how to begin and carry on a conversation. The classes were conducted once or twice a week for about an hour.

19.

Because L.C. continued to live in the hospital for years when most patients stayed for just a few weeks, she repeated the "communication skills" workshop over and over again. This repetition was also because L.C. was not able to complete the course. If she had managed to complete it, she would have attended other groups.

20.

L.C. did not learn any new skills in the communication group and often did not understand the classes but she enjoyed being permitted to join the classes.

21.

L.C. attended the evening hygiene group once or twice a week in the evenings for about 30 minutes to an hour.

22.

In addition to these activities, there was a short period when a teacher came to the unit twice a week to teach basic reading, writing, and math skills.

23.

The activities described in the above paragraphs filled only a small portion of L.C.'s days and evenings at the hospital. She very rarely had any visitors and never left the hospital grounds.

24.

As I observed the monotony of L.C.'s life in the mental hospital, I became increasingly frustrated with the complete lack of alternative residential options available to her.

25.

Beginning in December of 1993, I began meeting with a small group of individuals outside the hospital who were concerned about L.C., and had decided to follow an informal planning process called "futures planning" in an effort to find a way through the literal and figurative brick walls between L.C.'s present circumstances and a more

normal, integrated life in a non-institutional environment.

26.

The group has included advocates, L.C.'s family, hospital staff, staff from residential providers, and others; the group has now been meeting for more than eighteen months and L.C. still remains confined at GRH-A.

27.

I assisted another member of the hospital staff, Ms. Sherry Olvey, in the preparation of a letter to the hospital administration on L.C.'s behalf, seeking information about the possibility of allocating funds being spent for L.C. in the hospital toward a community placement. Specifically, the letter suggested that funds used for institutional care could, instead, be used to secure a supervised, federally-funded "medicaid waiver" placement for L.C. in the community.

28.

Ms. Olvey sent the letter to Ms. Elaine King, the Assistant Superintendent for Administration at GRH-A, in September, 1994.

29.

Ms. King responded that L.C. was not eligible for the state's medicaid waiver program because she was a psychiatric inpatient and, therefore, not a current Medicaid

recipient. She stated further that, although it cost the state \$208.00 a day to keep L.C. in the hospital, these were "fixed costs" and the hospital would not use money to support L.C. in the community, even if it cost less "on paper." (copy of letter attached as Exhibit 1)

30.

On September 27, 1994, at my request, Ms. Sue Jamieson, an attorney with Georgia's Protection and Advocacy program, wrote a letter to the hospital superintendent, the state office for mental retardation services, and two regional mental health/mental retardation directors seeking residential services for L.C. (copy of letter attached as Exhibit 2)

31.

On September 28, 1994, after reading the letter from Ms. King to Ms. Olvey, I wrote to Ms. King, further stressing my belief that medicaid waiver funding should be sought for L.C. (copy of letter attached as Exhibit 3)

32.

On December 12, 1994, after learning from Ms. Jamieson that she had received no response to her letter of September 27, I also wrote a letter to the state office of retardation services and to the director of the Fulton County Regional board which provides mental health and mental retardation services through contracts with the state and private providers. This is the entity which

serves residents of Fulton County, L.C.'s county of residence before she was institutionalized. (copy of letter attached as Exhibit 4)

33.

Although I was unable to identify any residential services for L.C., I referred her to a community day program called Community Friendship, Inc. (CFI) which provides a variety of services to mentally disabled persons designed to promote a sense of community and to enhance and develop the abilities of disabled individuals to function as fully as possible in increasingly independent, integrated settings.

34.

L.C. was promptly accepted in June, 1994, into the "social club" and then the "work adjustment" program at CFI.

35.

In August, 1994, I was finally able to arrange transportation for L.C. from the hospital to the CFI program through the public handicapped transportation system.

36.

L.C. has been attending the CFI programs from about 8:30 a.m. until 3:00 p.m. each weekday since August, 1994, to the present.

37.

During the last five months that I worked for GRH-A from August, 1994, to January, 1995, L.C. went each day on the bus to CFI. She became much more cheerful during this period and frequently expressed her great pleasure in the program and in her new friendships with staff and other participants at CFR. She would often talk about things that she did at the program, including the social activities and field trips.

38.

During this period, L.C.'s desire to leave the hospital became more intense and persistent; she was often sad when she had to return to the hospital at the end of the day and very disappointed when the bus did not arrive to transport her to the program in the morning, which happened about once every other week.

39.

I noticed that L.C.'s appearance and her attitude toward herself and others improved after she started to participate in the CFI program away from the hospital.

40.

After beginning the CFI program, L.C. would wait for the bus each morning unaccompanied by staff which resulted in the recognition by the hospital treatment team that she did not need staff supervision at all times.

41.

Since January, 1995, in my present position with TOPS, I have seen other persons with mental retardation with many fewer skills, problem behaviors, and much lower overall functioning levels than L.C. live successful and reasonably normal lives in homes and apartments with individualized supports.

Sworn to and subscribed
before me this 3rd
day of May, 1995.

/s/ J Gaston Golson
NOTARY PUBLIC
Notary Public, DeKalb County, Georgia
My Commission Expires October 31, 1997

/s/ Randy A. Brazee
RANDY A. BRAZEE

IN THE UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF GEORGIA
ATLANTA DIVISION

L.C., by JONATHAN ZIMRING	*
as guardian ad litem and next	* CIVIL ACTION
friend,	* FILE
	*
Plaintiff,	* NO. 1:95-CV-1210-
	* MHS
vs.	*
	*
TOMMY OLMSTEAD, Director of	*
the Department of Human	*
Resources; RICHARD FIELDS,	*
Superintendent of Georgia	*
Regional Hospital at Atlanta; and	*
ERNESTINE PITTMAN, Executive	*
Director of the Fulton County	*
Regional Board; all in their	*
official capacities,	*
	*
Defendants.	*

ANSWER AND DEFENSES

(Filed Jun. 2, 1995)

COME NOW the Defendants and answer and defend the Complaint as follows:

FIRST DEFENSE

The Complaint fails to state a claim upon which this Court may grant relief.

SECOND DEFENSE

There was no violation of any Constitutional right and no Constitutional deprivation was suffered by Plaintiff.

THIRD DEFENSE

The Defendants answer the numbered paragraphs of the Plaintiff's Complaint as follows:

1.

In response to paragraph 1, Defendants admit based on information and belief that Plaintiff is a 27 year old person with schizophrenia and mental retardation; that Plaintiff was admitted to Georgia Regional Hospital at Atlanta ("GRH-A") on or about May 11, 1992; that Plaintiff is currently living with her mother and receiving services in the community; and that at this time Plaintiff does not require inpatient psychiatric treatment. Defendants admit that GRH-A is a state hospital for the treatment of persons with mental illness and/or mental retardation. All allegations of paragraph 1 not admitted above are denied.

2.

The allegations of paragraph 2 through 5 are denied.

3.

Paragraph 6 sets forth legal conclusions and, hence, requires no answer of these Defendants; to the extent that

an answer is deemed required the allegations of said paragraph are denied.

4.

Without waiving any other defenses, Defendants admit the allegations of paragraph 7 and 8.

5.

In response to paragraph 9, Defendants admit based on information and belief that Plaintiff is 27 years old and has a diagnosis of mental retardation and schizophrenia; that her psychiatric symptoms have been generally stabilized for over two years; that she does not currently require inpatient psychiatric hospitalization; and that she resided in Fulton County prior to admission to GRH-A and that her mother lives in Fulton County. All allegations of paragraph 9 not admitted above are denied.

6.

In response to paragraph 10, Defendants admit that Tommy Olmstead is the Commissioner of the Department of Human Resources ("DHR") with all the duties and responsibilities attendant to that position. Defendants specifically deny that he is responsible for the operation of GRH-A and deny all other allegations of paragraph 10 not admitted above.

7.

In response to paragraph 11, Defendants admit that Richard Fields is the Superintendent of GRH-A, located in DeKalb County, Georgia, with all the duties and responsibilities attendant to that position, and that he is responsible for the administration of GRH-A. Defendants deny all other allegations of paragraph 11.

8.

In response to paragraph 12, Defendants admit that Ernestine Pittman is the Executive Director of the Fulton County Regional Board ("the Board") with all the duties and responsibilities attendant to that position, and deny all other allegations of paragraph 12.

9.

In response to paragraphs 13 through 24, Defendants show that these paragraphs state legal conclusions and arguments, and include partial quotes from various federal and state laws, and they thus require no response from these Defendants; to the extent an answer is deemed required, all allegations of paragraphs 13 through 24 are denied.

10.

In response to paragraph 25, Defendants admit based on information and belief that L.C. is a 27 year old African-American woman with mental retardation and a diagnosis of schizophrenia. Defendants further admit that various records state that L.C. is at times friendly, has a

beautiful smile, that she likes to draw, and that she has hypergraphia, or that she writes on paper excessively. All allegations of paragraph 25 not admitted above are denied.

11.

In response to paragraph 26, to the extent that Plaintiff intends this allegation to be a legal conclusion, no response if required of Defendants; without admitting to any legal conclusions, Defendants admit based on information and belief that Plaintiff has mental disabilities and is to some extent mentally disabled.

12.

In response to allegations of paragraph 27, Defendants admit based on information and belief records that L.C. has consistently been diagnosed with mild or moderate mental retardation, that she has only very elementary ability to read and write and that she has some ability to understand abstract concepts. All allegations of paragraph 27 not admitted above are denied.

13.

In response to paragraph 28, Defendants admit that GRH-A is a facility for the treatment of persons with mental illness, mental retardation and substance abuse problems and that it is owned and operated by the State and its agencies. Defendants further admit based on information and belief that L.C. has lived most of her life

since age 14 at GRH-A and other institutions. All allegations of paragraph 28 not admitted above are denied.

14.

In response to paragraph 29, Defendants admit the allegations of this paragraph, showing, however, that GRH-A also treats persons with mental retardation and has programs in addition to those described in the Complaint, including programs for persons with mental retardation.

15.

In response to paragraph 30, Defendants admit based on information and belief that L.C. resided at GRH-A for more than three years and deny all other allegations of paragraph 30.

16.

Defendants admit the allegations of paragraph 31, except that between 30 to 60 patients reside in each building, not in each unit as stated in this paragraph.

17.

Defendants admit the allegations of paragraph 32, except that the average number of patients in the building, not unit as stated in this paragraph, is 60, not 65.

50

18.

In response to paragraph 33, Defendants admit based on information and belief that in 1991 L.C. was placed in a community program for persons with mental retardation and that Project Rescue, a non-profit organization, was involved. All other allegations of paragraph 33 are denied.

19.

In response to paragraph 34, Defendants admit based on information and belief that L.C. was maintained in the community for about one year, with several shortterm admissions back to GRH-A. All other allegations of paragraph 34 are denied.

20.

In response to paragraph 35, Defendants show that an admission assessment dated May 11, 1992, states that L.C. was violent, hearing voices, wanted to return to GRH-A, was aggressive toward others, and attempted to harm a staff person with a knife. With regard to the remaining allegations of paragraph 35, these Defendants are without knowledge or information sufficient to form a belief as to the truth of the allegations in paragraph 35 of the Complaint and hence can neither admit nor deny same; to the extent that an answer is deemed required, the allegations of said paragraph are denied.

51

22.

The allegations of paragraph 36 are admitted.

23.

In response to paragraph 37, these Defendants are without knowledge or information sufficient to form a belief as to the truth of the allegations in paragraph 37 and hence can neither admit nor deny same; to the extent that an answer is deemed required, the allegations of said paragraph are denied.

24.

The allegations of paragraph 38 are denied based on information and belief.

25.

In response to paragraph 39, Defendants admit that the records include a treatment plan developed by GRH-A at the time of her hospitalization which included the stabilization of her mental illness. All other allegations of paragraph 39 are denied based on information and belief.

26.

In response to paragraph 40, based on information and belief Defendants deny the allegations as written, showing that once L.C.'s condition stabilized, a "partial hospitalization" program including community based day treatment services with hospitalization at night was

developed for L.C. All other allegations of paragraph 40 are denied based on information and belief.

27.

The allegations of paragraph 41 are denied.

28.

In response to paragraph 42, Defendants admit based on information and belief that in or about February 1993 a social worker sought mental retardation services including placement for L.C. All other allegations of paragraph 42 are denied based on information and belief.

29.

In response to paragraph 43, Defendants admit that the allegations quote parts of statements from a March 1993 Doctors Progress Note; in addition to the parts quoted by the Complaint, the doctor's note also states that L.C. had done better but remained delusional on neuroleptic medication.

30.

In response to the allegations of paragraphs 44 and 45, Defendants admit that these paragraphs quote parts of the record at GRH-A.

31.

In response to paragraph 46, Defendants admit that the allegations quote from part of an August 9, 1993, doctor's progress note, but show that the part quoted is so incomplete as to mischaracterize the note; Defendants show that in addition to L.C.'s problems with hygiene quoted in the complaint, the note also stated that L.C.'s urinating in the closet was one of L.C.'s problems.

32.

The allegations of paragraph 47 are admitted based on information and belief.

33.

The allegations of paragraphs 48 and 49 are denied.

34.

In response to the allegations of paragraph 50, Defendants deny that Plaintiff is confined at GRH-A. The remaining allegations are admitted based on information and belief, but Defendants show that GRH-A is not required to design an individualized habilitation program for L.C.

35.

The allegations of paragraph 51 are denied.

54

36.

The allegations of paragraph 52 are admitted as they apply to the time that L.C. was at GRH-A, but Defendants show that L.C. was appropriately placed and received adequate treatment at GRH-A.

37.

The allegations of paragraph 53 are denied based on information and belief.

38.

The allegations of paragraphs 54 and 55 are denied.

39.

In response to paragraph 56, the allegations of sentences 1 and 2 are denied based on information and belief. The allegations of sentence 3 are admitted, but Defendants show that L.C.'s treatment plan included personal hygiene education and training.

40.

In response to paragraph 57, Defendants deny based on information and belief that hospital staff often control L.C. with the administration of sedatives or psychotropic drugs when she is loud and disruptive. With regard to the remaining allegations of paragraph 57, these Defendants are without knowledge or information sufficient to form a belief as to the truth of the allegations in paragraph 57 of the Complaint and hence can neither admit

55

nor deny same; to the extent that an answer is deemed required, the allegations of said paragraph are denied.

41.

The allegations of paragraphs 58 and 59 are denied based on information and belief.

42.

The allegations of paragraphs 60 through 65 are denied.

43.

The allegations of sentence 1 of paragraph 66 are admitted. The allegations of sentence 2 of paragraph 66 are denied.

44.

The allegations of paragraphs 67 through 70 are denied.

45.

In response to paragraph 71, Defendants admit that there are various private and public providers in Georgia of supervised, community-based residential programs for persons with mental retardation. Defendants are without knowledge or information sufficient to form an opinion of the truth of the remaining allegations of paragraph 71 and hence can neither admit nor deny same; to the extent

56

a response is deemed required, said allegations are denied.

46.

The allegations of paragraph 72 are admitted based on information and belief.

47.

In response to paragraph 73, Defendants admit based on information and belief that L.C. is both mentally retarded and mentally ill and deny all other allegations of paragraph 73.

48.

The allegations of paragraph 74 are denied.

49.

In response to the allegations of paragraph 75, these Defendants are without knowledge or information sufficient to form a belief as to the truth of the allegations in paragraph 75 of the Complaint and hence can neither admit nor deny same; to the extent that an answer is deemed required, the allegations of said paragraph are denied.

50.

In response to paragraph 76, the allegations are too vague and ambiguous as to be capable of a response; to

57

the extent a response is deemed required, said allegations are denied.

51.

In response to paragraph 77, Defendants admit based on information and belief that L.C. received approximately the amounts listed in said paragraph.

52.

The allegations of paragraph 78 and 79 are admitted, except that Defendants show that state law requires the application of portions of the lump sum and monthly benefits to the cost of her care.

53.

In response to paragraph 80, Defendants admit based on information and belief that \$6740.80 of the social security benefits were applied toward the cost of her care at GRH-A; that approximately \$700.00 was spent on personal items needed by L.C.; that she has approximately \$2000.00 in a spending account; and that she has \$5000 in a burial account. All other allegations of paragraph 80 are denied.

54.

In response to paragraph 81, Defendants admit based on information and belief that GRH-A failed to submit a claim for available medicare insurance coverage on L.C.'s

behalf until recently. All other allegations of paragraph 81 are denied.

55.

In response to the allegations of paragraph 82, Defendants admit that L.C. had a right to a hearing but specifically deny that essentially all her funds were applied to the cost of her care.

56.

In response to paragraph 83, Defendants admit based on information and belief that notices regarding the procedures for requesting hearings were received by GRH-A. In regard to the remaining allegations of paragraph 83, these Defendants are without knowledge or information sufficient to form a belief as to the truth of the allegations in paragraph 83 of the Complaint and hence can neither admit nor deny same; to the extent that an answer is deemed required, the allegations of said paragraph are denied.

57.

In response to paragraph 84, Paragraph 84 of the Complaint sets forth legal conclusions and, hence, require no answer of these Defendants; to the extent that an answer is deemed required the allegations of said paragraph are denied.

58.

The allegations of paragraphs 85-91 are denied.

59.

In response to paragraph 92, Plaintiff merely states the relief she requests and said paragraph requires no response of Defendants; to the extent a response is deemed required, all allegations of paragraph 92 are denied.

60.

Any allegations of the complaint not admitted, denied or otherwise responded to above are denied.

WHEREFORE, having fully responded to the allegations of the complaint, Defendants pray that the complaint be dismissed, that all costs be taxed against Plaintiff, and for such other relief as the Court deems just.

Respectfully submitted,

MICHAEL J. BOWERS 071650
Attorney General

/s/ William C. Joy
WILLIAM C. JOY
by Pw/Rem. 405500
Senior Assistant Attorney
General

(Signatures continued on next page)

/s/ Patricia Downing
 PATRICIA DOWNING 228350
 Senior Assistant Attorney
 General

PLEASE ADDRESS ALL
 COMMUNICATIONS TO:

PATRICIA DOWNING
 Senior Assistant Attorney General
 40 Capitol Square, S.W.
 Atlanta, Georgia 30334-1300
 Telephone: (404) 656-3338

CERTIFICATE OF SERVICE

I do hereby certify that I have this day served the within and foregoing ANSWER AND DEFENSES, prior to filing the same, by depositing a copy thereof, postage prepaid, in the United States Mail, properly addressed upon:

Steven Caley
 Atlanta Legal Aid
 151 Spring Street
 Atlanta, Georgia 30303-2097

Sue Jamieson
 Atlanta Legal Aid
 340 W. Ponce de Leon Avenue
 Decatur, Georgia 30030

This 1st day of June, 1995.

/s/ Patricia Downing
 PATRICIA DOWNING

IN THE UNITED STATES DISTRICT COURT FOR THE NORTHERN DISTRICT OF GEORGIA ATLANTA DIVISION

L.C., by JONATHAN ZIMRING)
 as guardian ad litem and next)
 friend,)

Plaintiff,)

v.)

TOMMY OLMSTEAD, Director of)
 the Department of Human)
 Resources; RICHARD FIELDS,)
 Superintendent of Georgia)
 Regional Hospital at Atlanta; and)
 ERNESTINE PITTMAN, Executive)
 Director of the Fulton County)
 Regional Board, all in their)
 official capacities,)

Defendants.)

CIVIL ACTION

FILE NO.

1: 95-CV-1210

INTERVENOR'S COMPLAINT

PRELIMINARY STATEMENT

1.

L.C. is mentally retarded and filed this case after three years in a state mental hospital, confinement that continued contrary to the judgment of her treatment professionals that she needed alternative community placement. L.C.'s independent psychologist concurred with other psychological evaluations in past years that she should be viewed from a developmental rather than a psychiatric perspective and that prolonged psychiatric

institutionalization has been inappropriate and detrimental. After spending more than half of the past 14 years in mental hospitals and shortly after the case was filed, L.C. was placed on "trial visit" with her mother without adequate discharge planning or community services. There are no identified community-based alternatives to interrupt the 14-year pattern of inappropriate and prolonged psychiatric hospitalizations which occur when L.C.'s behavior becomes difficult to manage.

2.

Intervenor, E.W., resides in the same locked psychiatric ward where L.C. resided until her "trial visit." Like L.C., she is mentally retarded and needs habilitation to address her needs as a mentally retarded adult. E.W. has been confined there since October, 1994, although she does not require inpatient psychiatric care and could be served more appropriately in a structured and supervised community setting designed to serve mentally retarded persons. Her history of psychiatric confinements stretches back for years and includes a series of discharges to inappropriate and inadequate boarding homes. Recently, the hospital had planned to discharge E.W. to a homeless shelter but declined after E.W.'s attorney intervened on her behalf.

JURISDICTION

3.

Jurisdiction is conferred on this Court by 28 U.S.C. §§ 1331 and 1343 and 42 U.S.C. § 12133 in that this is an

action arising under the Americans with Disabilities Act, the United States Constitution, and 42 U.S.C. § 1983. Declaratory and injunctive relief is authorized by 28 U.S.C. §§ 2210 and 2202.

4.

Venue is proper under 28 U.S.C. § 1391.

PARTIES

5.

Plaintiff, E.W., is a 43-year-old mentally retarded woman who also has been diagnosed with a variety of mental disorders. She is currently confined in a psychiatric ward at Georgia Regional Hospital at Atlanta ("GRH-A") where she has been confined more than 30 times since 1975.

6.

Defendant Tommy Olmstead is the Commissioner of the Department of Human Resources ("DHR") and is responsible for the operation of GRH-A, for the protection of the rights of persons confined to GRH-A, and for the overall provision of services to persons suffering from mental retardation and mental illness in the State of Georgia.

7.

Defendant Richard Fields is the Superintendent of GRH-A, located in DeKalb County, Georgia. As such, he

is responsible for the operation of GRH-A, for the treatment of persons confined to GRH-A, and for the protection of rights of persons confined to GRH-A.

8.

Defendant Ernestine Pittman is the Executive Director of the Fulton County Regional Board (the "Board") and is responsible for the provision of mental health and mental retardation services, including community care and placement, for all residents of Fulton County.

FACTS

9.

E.W.'s most recent series of hospitalizations at GRH-A began in October, 1994. Since that date, she has been discharged to at least five different boarding homes for short periods of time and re-admitted because of behavior problems, serious side-effects to prescribed medication, suicidal behavior, and misconduct on the part of one of the boarding home operators. The last discharge to a personal care home on February 7, 1995, lasted for less than a day before she was re-admitted to the hospital because of verbal outbursts.

10.

In March, 1995, the hospital was planning to release her to a homeless shelter but agreed to seek a more appropriate placement after intervention by E.W.'s attorney.

11.

The decision to place E.W. in a shelter was based, in part, on the opinion of her physician that the mental hospital was an "overprotective" environment but the record does not reflect an effort to secure appropriate less "protective" community services designed to provide her with habilitation, structure, supervision, or psychiatric oversight.

12.

In April, 1995, E.W. secured an independent psychological evaluation which indicated that she had severe deficits in the areas of social skills and adaptive functioning and needed community placement in a supervised and structured residential setting designed for individuals with mental retardation and behavioral/emotional deficits; the evaluation also recommended participation in a sheltered workshop program and noted that E.W.'s many hospitalizations are due to possible inappropriate placements.

13.

On April 18th, 1995, a staffing was held to discuss E.W.'s placement but, upon information and belief, no alternative community services have been identified and E.W.'s confinement at GRH-A continues on an indefinite basis due to a perceived lack of community placements.

14.

Since the decision to discharge her to a homeless shelter was rescinded in March, 1995, E.W. experienced a severe medication reaction and has been hospitalized in a medical facility on an emergency basis for dehydration, indicating that discharge to a shelter, in addition to being clearly inappropriate, might have put her at serious medical risk.

15.

The GRH-A treatment unit where E.W. is confined is designed to provide short-term treatment to mentally ill persons in need of acute care and is not designed or staffed to provide the training, habilitation, education, or vocational skills, and behavioral management services that E.W. needs as a mentally retarded adult with behavior problems.

16.

E.W. is not receiving minimally adequate treatment or habilitation consistent with qualified professional judgment.

17.

In order for E.W. to receive minimally adequate treatment and habilitation to address her needs, including the problems resulting from years of inappropriate psychiatric institutionalization and lack of habilitation, she requires appropriate, community-based services.

18.

E.W. is institutionalized because of her disabilities but could be served in a more appropriate, integrated, community setting.

19.

During E.W.'s confinement at GRH-A, she has been secluded, placed in physical restraints, and administered sedative shots on a number of occasions without the development of a behavior management plan to enable E.W. to learn appropriate behaviors and avoid unnecessary or excessive use of restraints.

20.

Because E.W. is in a mental hospital, the policies, standards, and regulations applicable to the appropriate habilitation of mentally retarded persons in state, federal, and other publicly-funded programs, such as those that govern the use of restraint, seclusion, medication, and the development and implementation of habilitation plans, have not been followed by her treating professionals at GRH-A.

21.

Upon information and belief, none of the professionals on E.W.'s treatment team at GRH-A are qualified mental retardation professionals with experience or training in the habilitation of mentally retarded persons nor has E.W. been evaluated by any such professional on the

hospital staff until the intervention of her attorney referred to in Paragraph 10.

22.

The record also reveals that the hospital staff was and is without basic information regarding both the capacity of mentally retarded persons to live in the community with proper support and the capability of mental retardation community programs to deal with E.W.'s behavioral deficits.

23.

Minimal habilitation for E.W. would consist of specialized programs, training, and behavior management programs designed by mental retardation professionals to meet her individual needs.

24.

The minimally adequate setting for E.W.'s long-term habilitation is placement in the community.

25.

The state, through its county, regional, and contracted private providers operates a supervised, community-based residential program for persons with mental retardation. The cost of placement in such a program is substantially less expensive than the cost of institutional care.

26.

There are existing vocational, habilitative, social, and residential programs in the community operated fully or in part by the Defendants with the necessary experience, qualified staff, and the appropriate support and supervision to provide E.W. with the minimal habilitation that she needs in a much more integrated setting than her present institutional placement.

27.

At all times relevant to this Complaint, Defendants have acted under color of state law.

28.

Defendants' actions have caused and are continuing to cause Plaintiff irreparable harm.

CLAIMS FOR RELIEF

COUNT ONE - ADA

29.

Defendants have discriminated and are discriminating against Plaintiff on the basis of her disability in violation of Title II of the ADA, 42 U.S.C. § 12131 *et seq.* and the ADA's implementing regulations at 28 C.F.R. § 35.130.

COUNT TWO - FREEDOM FROM UNDUE RESTRAINT

30.

Defendants have violated and are violating Plaintiff's right to be free from undue restraint, guaranteed to her by the Due Process Clause of the Fourteenth Amendment.

COUNT THREE - RIGHT TO TREATMENT

31.

Defendants have failed and are failing to provide Plaintiff with treatment and discharge planning that is minimally adequate, in violation of her rights under the Due Process Clause of the Fourteenth Amendment.

COUNT FOUR - REGRESSION

32.

Defendants have failed and are failing to provide Plaintiff with the treatment and training that is necessary to prevent her pre-existing skills from deteriorating as a result of her institutionalization, in violation of her rights under the Due Process Clause of the Fourteenth Amendment.

COUNT FIVE

33.

TREATMENT RELATED TO
PURPOSE OF CONFINEMENT

Defendants have failed and are failing to provide Plaintiff with conditions of confinement that are reasonably related to the purpose of her confinement, in violation of her rights under the Due Process Clause of the Fourteenth Amendment.

COUNT SIX

34.

DEPRIVATION OF STATE-CREATED
LIBERTY INTEREST

Defendants have failed and are failing to provide Plaintiff with individualized treatment in the least restrictive environment or otherwise provide Plaintiff with appropriate discharge planning or proper treatment mandated by state law. Defendants' failure to provide such treatment mandated by Plaintiff's state-created liberty interest under the Due Process Clause of the Fourteenth Amendment.

PRAYER FOR RELIEF

35.

WHEREFORE, the Plaintiff-Intervenor prays that this Court:

- A. Assume jurisdiction of this case;
- B. Declare that Defendants' actions and failures to act as described above violate the ADA, the Fourteenth Amendment to the U.S. Constitution, and 42 U.S.C. § 1983;
- C. Preliminarily and permanently enjoin the Defendants from further violation Plaintiff-Intervenor's rights under the ADA, the Fourteenth Amendment, and 42 U.S.C. § 1983 and specifically requiring them to:
 - 1. Cease discriminating against Plaintiff on the basis of her disability;
 - 2. Provide Plaintiff-Intervenor with appropriate discharge planning, habilitation, training services and other treatment that comports with professional standards for the treatment of persons with mental retardation and mental illness including, but not limited to, release from GRH-A into a community-based residential program;
 - 3. Require that all discharge planning, habilitation, training services, and other treatment be provided by professionals qualified by education, training, and experience to provide such services;

- 4. Provide Plaintiff-Intervenor with individualized treatment in the least restrictive environment with the ultimate goal of integrating Plaintiff into the mainstream of society;
- 5. Provide Plaintiff-Intervenor minimally adequate treatment to prevent deterioration of her preexisting skills and that is related to the purpose of her confinement;
- 6. Cease unduly restraining Plaintiff's freedom of movement.
- D. Award Plaintiff-Intervenor costs and attorney's fees and
- E. Award any other relief the Court deems just and equitable.

/s/
 SUSAN C. JAMIESON
 Georgia Bar No. 389408
 340 West Ponce de Leon
 Avenue
 Decatur, Georgia 30030
 (404) 377-0701

/s/
 STEVEN D. CALEY
 Georgia Bar. No. 102866
 151 Spring Street
 Atlanta, Georgia 30303
 (404) 614-3926

ATTORNEYS FOR PLAINTIFF
 AND PLAINTIFF-INTERVENOR

IN THE UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF GEORGIA
ATLANTA DIVISION

L.C., by JONATHAN ZIMRING)	
as guardian ad litem and next)	
friend,)	
Plaintiff,)	CIVIL ACTION
v.)	FILE NO.
)	1: 95-CV-1210
TOMMY OLMSTEAD, Director of)	
the Department of Human)	
Resources; RICHARD FIELDS,)	
Superintendent of Georgia)	
Regional Hospital at Atlanta; and)	
ERNESTINE PITTMAN, Executive)	
Director of the Fulton County)	
Regional Board, all in their)	
official capacities,)	
Defendants.)	

CERTIFICATE OF SERVICE

This is to certify that I have this day served the opposing party in the foregoing matter with a copy of the Intervenor's Complaint by depositing in the United States mail a copy of same in a properly addressed envelope with adequate postage thereon to:

Patricia Downing
Sr. Asst. Attorney General
40 Capitol Square
Atlanta, Georgia 30334

This 16th day of June, 1995.

/s/ Susan C. Jamieson
SUSAN C. JAMIESON

IN THE UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF GEORGIA
ATLANTA DIVISION

[Caption Omitted In Printing]

CONSENT ORDER

* * *

2. Defendants shall discharge Plaintiff from Georgia Regional Hospital at Atlanta to the Brook Run facility in Atlanta, a facility for persons with mental retardation, effective July 27, 1995, on a temporary basis pending the completion of the assessments listed above and the development of a final plan regarding appropriate community services for Plaintiff, including placement.

* * *

**IN THE UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF GEORGIA
ATLANTA DIVISION**

L.C., BY JONATHAN ZIMRING,	*
as guardian ad litem	*
and next friend,	*
	*
Plaintiff,	*
	*
v.	*
	*
TOMMY OLMSTEAD,	*
Commissioner of the Department	*
of Human Resources; RICHARD	*
FIELDS, Superintendent of	*
Georgia Regional Hospital at	*
Atlanta; and ERNESTINE	*
PITTMAN, Executive Director of	*
the Fulton County Regional	*
Board, all in their official	*
capacities,	*

Civil Action No.
1:95-CV-1210-
MHS

**DEFENDANTS' RESPONSE TO
INTERVENOR'S COMPLAINT**

(Filed Feb. 20, 1996)

COME NOW Defendants and answer and defend the Intervenor's Complaint as follows:

FIRST DEFENSE

The Complaint fails to state a claim upon which relief may be granted.

SECOND DEFENSE

There was no violation of any constitutional right and no constitutional deprivation was suffered by Intervenor.

THIRD DEFENSE

Defendants answer the numbered paragraphs of the Intervenor's Complaint as follows:

1.

Defendants deny paragraph 1 of Intervenor's Complaint as written showing that L.C. is mentally ill and mentally retarded; that she has been treated for many years in a state mental hospital and at the time this lawsuit was filed she had been receiving treatment at Georgia Regional Hospital at Atlanta ("GRH-A") for three years. Defendants further admit that L.C. was referred for a psychological evaluation for alternate placement by her attorney, Susan M. Jamieson, and that the evaluation stated that it would be more valuable to view her from a developmental rather than a psychiatric perspective. Defendants further admit based on information and belief that L.C. has lived most of her life since age 14 at GRH-A and other institutions, including a brief incarceration for attempting bodily harm against her sister; and that before this case was filed, L.C. was scheduled for a "trial visit" with her mother and that the trial visit began shortly after the case was filed. All allegations of paragraph 1 not admitted above are hereby denied.

2.

Defendants deny paragraph 2 as written, showing that Intervenor resides in the same psychiatric treatment unit where L.C. resided prior to her trial visit, and that the unit is locked; that Intervenor is mentally ill and mentally retarded and that she may benefit from an individualized habilitation program to address her needs as a mentally retarded and mentally ill adult; that E.W. has been receiving treatment at GRH-A since December 20, 1994, not October, 1994 as stated in the Complaint; that based on information and belief, E.W. was originally admitted for hospitalization at GRH-A on March 7, 1975 and that she has been discharged at times to personal care homes; that in March 1995 when E.W. requested discharge, GRH-A planned to discharge her, was unable to locate a personal care home which would take her back, and E.W. had no plans for placement other than a homeless shelter, but that after E.W.'s attorney, Susan M. Jamieson, and others intervened, E.W. agreed to voluntarily stay at GRH-A, and GRH-A agreed to continue her voluntary treatment at the hospital. All allegations of paragraph 2 not admitted above are hereby denied.

3.

In response to paragraph 3, this paragraph merely states legal conclusions and hence no response is required of these Defendants. To the extent that a response is deemed required, said allegations are denied.

4.

The allegations of paragraph 4 are admitted.

5.

In response to paragraph 5, Defendants admit that E.W. is a 44-year old woman who has been diagnosed during this admission as having mild to moderate mental retardation, border-line personality disorder, and psychotic disorder NOS ("not otherwise specified"); that she is currently being treated in a psychiatric unit at GRH-A and that she has had over thirty (30) admissions since 1975. All allegations of paragraph 5 not admitted above are denied.

6.

In response to paragraph 6, Defendants admit that Tommy Olmstead is the Commissioner of the Georgia Department of Human Resources ("DHR") with all the duties and responsibilities attendant to that position. Defendants specifically deny that he is responsible for the operation of GRH-A and deny all other allegations of paragraph 6 not admitted above.

7.

In response to paragraph 7, Defendants admit that Richard Fields is Superintendent of GRH-A, located in DeKalb County, Georgia, with all the duties and responsibilities attendant to that position, and that he is responsible for the administration of GRH-A. Defendants deny all other allegations of paragraph 7.

8.

In response to paragraph 8, Defendants admit that Ernestine Pittman is the Executive Director of the Fulton County Regional Board ("the Board") with all the statutory duties and responsibilities attendant to that position, and deny all other allegations of paragraph 8.

9.

In response to paragraph 9, Defendants admit that E.W. has been admitted to GRH-A three times since October 8, 1994, and that her admissions since October 8, 1994 have been because of behavior problems, side effects to prescribed medication, suicidal behavior, and misconduct on the part of one of the personal care home operators; that she was placed on a trial visit in a personal care home on February 7, 1995 and that she was returned to GRH-A within one day because of her verbal outbursts. All other allegations of paragraph 9 not admitted above are denied.

10.

Defendants deny paragraph 10 as written, showing that in March 1995, when E.W. requested discharge, GRH-A planned to discharge her, was unable to locate a personal care home which would take her back, and E.W. had no plans for placement other than a homeless shelter, but that after E.W.'s attorney, Susan M. Jamieson, and others intervened, E.W. agreed to voluntarily stay at GRH-A, and GRH-A agreed to continue her voluntary

treatment at the hospital. All allegations of paragraph 10 not admitted above are hereby denied.

11.

The allegations of paragraph 11 are denied.

12.

In response to paragraph 12, Defendants admit that in April, 1995, E.W. was referred for a psychological evaluation by her attorney, Susan M. Jamieson. Defendants deny that the Complaint accurately reflects the conclusion of the evaluation, and show that the evaluation indicated that E.W. had severe deficits in the area of adaptive functioning, and profound (not severe as stated in the Complaint) deficits in the area of social skills. Defendants show that the evaluation did not state that she needed a community placement as stated in the Complaint; but rather stated that "if she is discharged from Georgia Regional she needs to have a highly structured residential home appropriate for an individual with mental retardation and behavioral/emotional deficits." Defendants admit that the evaluation also stated that her attorney, Ms. Jamieson, expressed the opinion that E.W. had been in inappropriate placements, and it recommended participation in a sheltered workshop program appropriate for a mentally retarded individual who has been institutionalized many times due to possible inappropriate placements. All allegations of paragraph 12 not admitted above are denied.

13.

In response to paragraph 13, Defendants admit that on April 18, 1995, a staffing was held to address Sue Jamieson's Complaint and concerns regarding E.W.'s placement and that Sue Jamieson attend the staffing. All allegations of paragraph 13 not admitted above are denied.

14.

In response to paragraph 14, Defendants admit that in May, 1995, E.W. was hospitalized in a medical hospital for dehydration to her refusing to eat or drink. All other allegations of paragraph 14 are denied.

15.

Defendants deny paragraph 15 as written, showing that the GRH-A treatment unit where E.W. is treated is designed to provide short-term and long-term treatment to mentally ill persons and that GRH-A provides all the training, rehabilitation, education, vocational skills, and behavioral management services that E.W. may need at different times, although E.W.'s particular unit may not always provide these services. Any allegations of paragraph 15 not admitted above are denied.

16.

The allegations of paragraph 16 are denied.

17.

The allegations of paragraph 17 are denied.

18.

In response to paragraph 18, Defendants admit that E.W. is institutionalized because of her disabilities and deny all other allegations of paragraph 18.

19.

Defendants deny paragraph 19 as written, showing that during E.W.'s treatment at GRH-A, it has been necessary to place her in seclusion or physical restraints, or to administer sedative shots at different times, even though an individualized treatment plan had been developed to enable E.W. to develop appropriate behaviors and avoid unnecessary or excessive use of restraints. Defendants further show that during part of her hospitalization a formal behavior management plan had not been developed but show that one was not required. All other allegations of paragraph 19 are denied.

20.

Defendants deny the allegations of paragraph 20 as written, showing that the policies, standards and regulations applicable to the treatment of persons in a psychiatric facility are different than the policies, standards, and regulations applicable to persons in an Intermediate Care Facility For the Mentally Retarded ("ICF-MR"), including

those that govern the use of restraint, seclusion, medication, and the development and implementation of rehabilitation plans; therefore, the policies, standards, and regulations applicable to an ICF-MR facility do not apply to E.W., because she is being treated on a psychiatric unit. All allegations of paragraph 20 not admitted above are denied.

21.

The allegations of paragraph 21 are denied.

22.

The allegations of paragraph 22 are denied.

23.

The allegations of paragraph 23 are denied.

24.

The allegations of paragraph 24 are denied.

25.

In response to paragraph 25, Defendants admit that the State's regional boards contract with community service boards and/or with private providers to provide supervised, community-based residential programs for some persons with mental retardation. Defendants further admit that generally the cost of placement in such a program is less expensive than the cost of institutional

care, but this varies with the individual needs of the consumer. All other allegations of paragraph 25 are denied.

26.

The allegations of paragraph 26 are denied.

27.

Paragraph 27 merely states a legal conclusion and requires no response of Defendants; to the extent a response is deemed required, the allegations of paragraph 27 are denied.

28.

The allegations of paragraphs 28 through 34 are denied.

29.

In response to paragraph 35, this paragraph merely states the relief desired by Plaintiff Intervenor and requires no response of these Defendants; to the extent a response is deemed required, any allegations of paragraph 35 are denied.

30.

Any allegations not admitted, denied or otherwise responded to above are hereby denied.

WHEREFORE, having fully responded to the allegations of Plaintiff Intervenor's Complaint, Defendants pray that the Complaint be dismissed, that costs be taxed against Plaintiff Intervenor, and for such other relief as the Court deems just.

Respectfully submitted,

MICHAEL J. BOWERS 071650
Attorney General

GEORGE P. SHINGLER 642850
Deputy Attorney General

/s/ W. F. Amideo
WILLIAM F. AMIDEO 016010
Senior Assistant Attorney
General

/s/ Patricia Downing
PATRICIA DOWNING 228350
Senior Assistant Attorney
General

PLEASE ADDRESS ALL
COMMUNICATIONS TO:

PATRICIA DOWNING
Senior Assistant Attorney General
40 Capital Square, S.W.
Atlanta, GA 30334-1300
Telephone: (404) 656-5161 ..

CERTIFICATE OF SERVICE

I do hereby certify that I have this day served the within and foregoing **DEFENDANTS' RESPONSE TO INTERVENOR'S COMPLAINT**, prior to filing the same, by depositing a copy thereof, postage prepaid, in the United States Mail, properly addressed upon:

Susan C. Jamieson
ATLANTA LEGAL AID
SOCIETY, INC.
DeKalb/Gwinnett Office
340 West Ponce de Leon Avenue
Decatur, GA 30030

Sylvia B. Caley
ATLANTA LEGAL AID
SOCIETY, INC.
151 Spring Street
Atlanta, GA 30303

Steven D. Caley
ATLANTA LEGAL AID
SOCIETY, INC.
151 Spring Street
Atlanta, GA 30303

This 19th day of February, 1996.

/s/ Patricia Downing
PATRICIA DOWNING
Senior Assistant
Attorney General

In the United States District Court
For the Northern District of Georgia
Atlanta Division

[Caption Omitted In Printing]
Plaintiffs' Statement Of Material Facts

* * *

21.

On March 20, 1995, Attorney Susan C. Jamieson filed a formal administrative complaint with Dr. Richard Fields asserting that the plan to discharge E.W. to a homeless shelter was inappropriate. Exh. 4.

22.

Following the complaint by Susan Jamieson, E.W. was not discharged. Patel II dep. exh. 2, p. 2 introduced at p. 28, l. 3-6; Parrish dep. p. 95, l. 1-11.

* * *

54.

A suitable placement for E.W. could be a group home for upper level mentally retarded with or without some degree of mental illness, with strong staffing and with available day programs, including vocational rehabilitation, and treatment activities if necessary. DeBacher dep. p. 27, l. 11-16.

* * *

57.

Dr. Patel felt that E.W. could have been treated as an outpatient in March 1995. Her behavior problems are long term problems and could be addressed in the community.

* * *

70.

The Mental Retardation Waiver Program is a program providing funding for individually designed community placements and necessary community services. The Mental Retardation Waiver Program provides a flexible funding mechanism to meet individuals' needs for community services. The funding source is Medicaid so that the State contributes approximately 40% of the funds and the federal government contributes the remaining 60%. The purpose of the Mental Retardation Waiver Program is to improve the lives of individuals by providing them with community services while saving the state money by avoiding costly institutional care.

* * *

81.

L.C.'s needs can be met by placing her in an appropriate community residential setting with adequate supports.

* * *

The treatment unit at GRH-A, where L.C. was confined from May, 1992, until May, 1995, is a single, large building divided into separate sleeping areas for men, women, or co-ed with a typical patient census of about 65 patients. Most patients stay for a short time until the acute symptoms of psychiatric illnesses have been stabilized.

* * *

L.C. was re-institutionalized at Brook Run, a mental retardation institution, even though she did not need institutional care. Patel I dep. p. 123, l. 5-21, p. 9-15.

L.C. was placed at Brook Run because there was no other alternative. Patel I dep. p. 123, l. 14-17.

* * *

During the three years that [L.C.] was confined at GRH-A from May 1992 until May 1995, no individual habilitation program was designed or implemented for her by qualified mental retardation professionals.

* * *

The institutional environment at GRH-A, peopled by individuals in crisis and acute psychotic states, is chaotic and complex.

* * *

L.C.'s physician at GRH-A, Dr. Ramesh Amin, notes that placement is a problem for L.C. in August of 1993. Dr. Amin felt that a community placement for L.C. would have needed 24 hour supervision, day treatment, and vocational rehabilitation. By November 1993 L.C.'s treatment team was looking for a community placement for her. GRH-A records, 8/9/93, progress notes, Exh. 53; Amin dep. p. 61, l. 8-19, p. 60, l. 7-13.

* * *

L.C.'s social worker at GRH-A in December, 1993, noted that "placement is a possibility with the right services linked up." GRH-A record, 12/1/93, progress notes, Exh. 55.

L.C. could have been placed in the community no later than 1993 if the focus of treatment had been on her developmental disabilities and the pharmacologic approach had been different. Elliott II dep. p. 81, l. 15-21.

* * *

160.

Mr. Brazee, L.C.'s social worker, attempted to find a placement for her through the Mental Retardation Waiver Program. Together with Ms. Sherry Olvey, Mr. Brazee sent a letter to Elaine King, the assistant superintendent for administration at GRH-A in September 1994. Brazee Aff. ¶¶ 27, 28, Exh. 29.

* * *

164.

Capable providers exist to treat person such as E.W. in the community.

165.

Community Placements are available if there is money to fund them.

* * *

170.

When the Georgia legislature passed H.B. 100, O.C.G.A. §37-2-5.1(c), it allowed the Mental Health, Mental Retardation, and Substance Abuse (MH/MR/SA) Division to transfer monies from state institutions to community placements so that more people could be served in the community.

171.

The U.S. government has authorized matching federal dollars to fund 2,109 community placements through the Medicaid Waiver Program, yet the State of Georgia is using only 700 of these slots.

* * *

174.

The per diem cap for community placements under the Medicaid Waiver Program for the mentally retarded is approximately \$118 to \$124 unless you request an exception.

175.

For FY '96, the per diem cost for institutional care at the Developmental Learning Center of GRH-A is \$283.

176.

For FY '95, the "adult psychiatric" per diem rate for institutional care at the Treatment Unit of GRH-A was \$219 (\$79,935 annually) and the "extended care" per diem cost was \$505 (\$184,325 annually).

* * *

IN THE UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF GEORGIA
ATLANTA DIVISION

[Caption Omitted In Printing]

AFFIDAVIT OF RICHARD L. ELLIOTT, M.D., PH.D.

* * *

12.

E.W.'s continued hospitalization at GRH-A has and will continue to have a negative impact on her treatment and habilitation because it is likely to contribute to her depression, dependence, and lack of motivation and because what E.W. needs, more than any other single component in her treatment, is an opportunity to learn how to develop and enhance her existing abilities in a community, rather than institutional, context.

* * *

IN THE UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF GEORGIA
ATLANTA DIVISION

[Caption Omitted In Printing]

AFFIDAVIT OF RICHARD L. ELLIOTT, M.D., Ph.D.

Personally appeared before me, the undersigned officer authorized to administer oaths, Richard. L. Elliott, M.D., Ph.D., who, after being duly sworn, states:

1.

My name is Richard L. Elliott, and I am more than 18 years of age. I suffer from no legal disability and am competent to testify to the matters set forth herein.

2.

This affidavit is made upon my personal knowledge of the matters set forth herein and based on my professional judgment and opinion.

3.

I am currently program director and a professor in the department of psychiatry and behavioral science and the director of the center for public health advocacy at Mercer University School of Medicine, Macon, Georgia. My curriculum vitae attached to this affidavit contains accurate information regarding my educational and professional background and publications.

4.

At the request of counsel for E.W. and L.C., I have evaluated both individuals and formed certain opinions, including whether each had received minimally adequate treatment at Georgia Regional Hospital-Atlanta (GRH-A) and whether each could have been placed in a more appropriate, integrated setting instead of remaining in a psychiatric institution. My opinions on these matters were summarized in two reports dated February 26, 1996, (E.W.) and May 17, 1996 (L.C.). I have also been deposed twice by defendants' counsel and prepared an affidavit in July, 1996. The affidavit addressed the increasingly serious problems created for E.W. by her continuing institutional confinement.

5.

The opinions and conclusions expressed in those reports, depositions, and the affidavit, have not changed with the exception that my opinion regarding the adequacy of L.C.'s current placement was based on my observations and the information provided about the community-based services being provided to her in May, 1996, when I visited the residential placement ("Nyasha Hands") on Midway Road in Decatur, Ga.

6.

If L.C. is no longer residing at "Nyasha Hands," no longer attending the Community Friendship day program, and no longer involved with the same staff, I am

unable to reach any conclusions about the adequacy of her current placement.

7.

In the case of L.C., the clinical history indicates that she was placed repeatedly in psychiatric hospitals over a 14-year period, beginning when she was a young child. The records further indicate that these hospitalizations were often because her mother found L.C.'s behavior difficult to manage. L.C.'s life has thus been substantially disrupted by psychiatric hospitalizations, despite consistent indications throughout this long history that more support and structure as well as developmental and behavior management training was needed to enable L.C. to function in a community, rather than an institutional setting.

8.

Because of L.C.'s mental retardation, minimally adequate habilitation must focus on the acquisition and maintenance of life skills which will enable her to cope more effectively with her own needs and with the environment and it must focus on raising the level of her physical, mental, social, and vocational abilities. Her lengthy history in psychiatric hospitals provides clinical evidence that, in her case, this type of habilitation has not been and cannot be accomplished in this setting.

9.

Since at least 1986, professionals with a background and expertise in mental retardation have consistently

noted that L.C.'s needs as a mentally retarded adult cannot be adequately met in a psychiatric hospital, although brief periods of hospitalization may occasionally be necessary to stabilize acute psychiatric symptoms.

10.

In order to break her pattern of constant re-hospitalizations, L.C. must have the opportunity to learn to manage her behavior in a staffed, supportive, and structured community setting. L.C., because of her mental retardation, does not successfully transfer what is learned about managing behavior (and other social and adaptive skills) from an institution to a community setting. Also, because of her mental retardation, L.C. has probably learned maladaptive behavior as a direct result of her institutionalization in psychiatric facilities since she models the behavior which she observes.

11.

For L.C., habilitation in the community is needed at this point to counteract the dependency and lack of skill development resulting from years of institutionalization, much of which may have been unnecessary and inappropriate.

12.

For E.W., the bases for my conclusion that she requires habilitation in the community rather than in an institution are essentially the same as those upon which my conclusions regarding L.C. are based.

13.

In E.W.'s case, the constant, repetitive psychiatric hospitalizations provide clinical evidence that this revolving door cycle is increasingly counterproductive.

14.

Like L.C., it is unlikely that E.W. can learn how to maintain and enhance her capacity for independence, acquire and maintain those life skills which will enable her to cope more effectively with her needs and with her environment, and receive the kind of habilitation needed to raise the level of her physical, mental, social, and vocational abilities while in a psychiatric institution; such goals must be advanced in order to provide her with minimally adequate habilitation.

15.

E.W., while exhibiting signs of learned dependence on institutional routines, also suffers from frustration, depression, and hopelessness in an institutional setting.

16.

Like L.C., E.W.'s combination of emotional problems and mental retardation, require a supported, structured environment within which she would have the only realistic opportunity to maintain and acquire the behavioral and adaptive skills needed to live with reasonable success in the community. Based on my review of E.W.'s individual clinical history, this opportunity cannot be provided in a psychiatric institution.

17.

Under these circumstances, therefore, E.W. requires habilitation services in a community setting to provide her with the opportunity to acquire the skills she needs to live outside of an institution.

18.

In light of L.C.'s and E.W.'s particular capabilities, disabilities, and clinical histories, habilitation must be provided to them in an environment where their existing skills can be maintained and where they have an opportunity to increase their capacity to function more independently. For E.W. and L.C., this cannot be accomplished in a psychiatric institution.

Further the affiant saith not.

This 16th day of August, 1996.

/s/ Richard L. Elliott, MD PhD
Richard L. Elliott, M.D., Ph.D.

Sworn to and subscribed
before me this 16
day of August, 1996.

/s/ Illegible Morris
NOTARY PUBLIC

My Commission Expires
Jan. 10, 2000

Dr. Debacher's Evaluation of E.W., Undated, Fall 1995

* * *

Elaine has become so worn out in this environment that she would benefit from a complete change of scene to help her climb out of her depression and take renewed interest in life. Our hospital was never intended for long-term habilitation (except DLC which serves lower functioning retardates), and our relatively spartan physical and social environment is intended to inspire patients to return quickly to life outside. It is unavoidably lacking as a long-term growth environment.

* * *

ATLANTA LEGAL AID SOCIETY, INC.
~~DEKALB~~/GWINNETT OFFICE
 340 WEST PONCE DE LEON AVENUE
 DECATUR, GEORGIA 30030
 (404) 377-0701
 (FAX (404) 377-2349

[LETTER HEAD OMITTED IN PRINTING]

March 20, 1995

Richard Fields, M.D.
 Superintendent
 Georgia Regional Hospital at Atlanta
 3073 Panthersville Road
 Decatur, Georgia 30034

Re: ELAINE WILSON
 formal Complaint
 GRH-A/Protection and Advocacy Policy
 1160

Dear Dr. Fields:

Ms. Wilson, age 43, is a patient on the Treatment Unit, who has been unable to resolve her complaint at the unit level and is at serious and immediate risk of inappropriate discharge to a homeless shelter or personal care home without adequately trained staff.

We learned of Ms. Wilson's impending discharge on Friday, March 17, 1995. Pursuant to the above policy, I contacted the consumer specialist, Ms. Sherry Olvey, but she was unable to reach the client's physician, Dr. Patel. Ms. Olvey did promise that Ms. Wilson would not be released until a meeting was scheduled with hospital staff to consider placement options. On March 20, 1995, Ms. Olvey contacted us to advise that the treatment team still

intended to discharge to a shelter but they would give Ms. Wilson's mother "a few days or a week" to locate placement. No further meetings are planned.

In light of the risk to Ms. Wilson, I do not feel I can wait before initiating this formal process, although we are always hopeful that solutions to complaints can be secured informally. Our concern is that a review of Ms. Wilson's record on March 17th clearly indicated that her treatment team intends to release her to a shelter. Her social worker, according to the record, awaits a contact from the Homeless Task Force for shelter placement.

Ms. Wilson is mentally ill, mentally retarded, and in need of appropriate, supervised, community-based mental health services and habilitation. She is incontinent of urine and feces and has behavior problems, all of which would, we believe, make shelter placement punitive, remarkably inappropriate, and absolutely doomed to failure. It strikes us as the complete opposite of what the new Mental Health Code promises Georgia's mentally disabled as well as a specific violation of her right to assistance in securing appropriate community services and programs. The record does not reflect any contact with mental retardation services, supportive living, supervised group home options, etc.

I look forward to a prompt investigation and response.

Sincerely,

Susan C. Jamieson

SCJ/b

**IN THE UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF GEORGIA
ATLANTA DIVISION**

[Caption Omitted In Printing]

AFFIDAVIT OF DR. DILIPKUMAR PATEL

* * *

1.

My name is Dilipkumar Patel and I am over the age of majority and have no disabilities which would render me incompetent to give this affidavit. I make this affidavit in support of Defendants' motion for summary judgment in the above referenced case, which I understand is being filed with the court. Records which are attached hereto are copies of E.W.'s medical records which are kept in the course of business at Georgia Regional Hospital at Atlanta.

2.

I am a Board Certified Psychiatrist licensed to practice in Georgia. I received my Medical Degree from Baroda, India, in 1979, after completing a year of internship. I undertook post-graduate studies for approximately a year and a half after I received my M.D., and I then immigrated to the United States in 1980. From 1980 to 1984 I worked with physicians at the Medical Center in Brooklyn, New York, and other hospitals. I completed my residency at St. Francis Hospital in Pittsburgh, Pennsylvania, from 1984 to 1988. That hospital is a psychiatric hospital and I treated patients with a broad range of problems including mental illness, mental retardation,

and substance abuse. I was then licensed to practice in Georgia, and I became board Certified in Psychiatry in 1991.

3.

I started work at Georgia Regional Hospital in 1988. In July 1994 I became the Medical Director of the Treatment Unit at Georgia Regional Hospital at Atlanta, which is a 60-bed unit for treatment of patients with acute and long term psychiatric illnesses.

4.

I treated L.C. on the Treatment Unit in July 1994. Her diagnosis was Schizophrenia, Undifferentiated Type, Chronic; and Mild Mental Retardation.

5.

During this time, and the entire time she was at GRH-A, L.C.'s treatment was provided under an individualized Treatment Plan developed by appropriate professionals who were adequately trained to assess L.C. and to recommend her treatment. The treatment which was provided to L.C. under her treatment plan was at all times appropriate for her needs. At all times that L.C. was at GRH-A, in my opinion she needed to be there for treatment.

6.

Prior to L.C.'s trial visit with her mother starting in May 1995, it was my opinion that she was not ready for discharge.

7.

In regard to E.W., her records show that she was first hospitalized at age 14 at Gracewood State School and Hospital where she was diagnosed as having mild to moderate mental retardation. She was later hospitalized at Central State Hospital with a diagnosis of schizophrenia.

8.

She was admitted to GRH-A for the first time in approximately 1974 and was frequently readmitted during the 1980's. In 1987 she was admitted to GRH-A for reportedly attacking a home provider and the provider's grandchild with a knife.

9.

Her diagnoses at various times have included Organic Personality Syndrome; Adjustment Reaction; Schizoaffective Disorder; Psychotic Disorder, Not Otherwise Specified; Borderline Personality Disorder; and Mild to Moderate Mental Retardation.

10.

E.W. was involuntarily admitted to my Unit on December 20, 1994 based in part on a Form 1013, which is an "Emergency Admission Certificate" signed by a licensed physician, psychologist or clinical social worker. The certificate stated that E.W. appeared to be mentally ill, that she had auditory and visual hallucinations, was paranoid, and was too "loose" to care for herself. (Doc. No. 9440)

11.

On admission to GRH-A, E.W. was examined by a psychiatrist who stated that she "reports visual hallucinations (demons)," and also that she "reports hearing the voice of her grandfather." He also noted that she reported feeling groggy and falling down since her medication was changed. (Doc. Nos. 8605 and 8606) His diagnostic impression was that she had a drug induced psychotic disorder, mild mental retardation by history, borderline personality disorder by history, and various physical disorder, including obesity, urinary incontinence to be studied, and a toxic reaction to Tegretol.

12.

On this admission, E.W. was 44 years old and had been admitted to this hospital more than 30 times since 1975. Her record included reports of auditory and visual hallucinations, delusions, aggressive and violent behavior, suicidal behavior, and depression. In my opinion her

diagnosis is Borderline Personality Disorder and Mild Mental Retardation.

13.

E.W. consented to voluntary treatment on December 30, 1995. (Doc. No. 8978) A treatment plan was developed for E.W. by the treatment team, including myself, the case manager/social worker, nurse, activity therapist, and social work supervisor. Her symptoms identified in the plan included her reaction to Tegretol, verbally abusive behavior, physical aggression, potential for noncompliance in placement, hygiene, and overflow incontinence. (Doc. Nos. 8671, 8672, 8675, 8677, 8684) Her treatment included medication, activity therapy, structure, group therapy, hygiene class, and other classes.

14.

On three occasions E.W. stabilized, and it was decided by myself and the treatment team that she should go on a trial visit away from the hospital in transition to discharge. In December of 1994 and in January and February of 1995, trial visits were arranged to personal care homes. However, on these occasions E.W. was returned to the hospital due to (1) her abusive verbal outbursts and apparent suicidal behavior (running into the street) (December) (Doc. No. 9441), (2) misconduct on the part of a personal care home staff and E.W.'s threat to the kill staff (January) (Doc. No. 8985), and (3) her hostile behavior and abusive verbal outbursts (February) (Doc. No. 9083).

15.

We continued to treat E.W. as a voluntary patient at GRH-A. However, in March, E.W. refused to cooperate with her treatment and tore up her treatment plan during a treatment team meeting. Although I can begin an involuntary commitment procedure for a voluntary patient who withdraws consent for voluntary treatment, E.W. did not meet the criteria for involuntary commitment at that time so I did not initiate the involuntary commitment procedures. Therefore, it was decided by myself and the treatment team that she should be discharged.

16.

E.W.'s attorney, Sue Jamieson, made a complaint at that time. As I understood her complaint, she wanted the hospital to keep E.W. until a community placement for E.W. including mental retardation services was provided, and she also believed the primary focus of her treatment should be on E.W.'s mental retardation instead of her mental illness.

17.

In response to Ms. Jamieson's complaint, I consulted with Dr. Gary DeBacher, Chief of the Psychology Staff, and Willie Ingram, Team Coordinator, from the Developmental Learning Center, GRH-A's Intermediate Care Facility for the Mentally Retarded (ICF/MR).

18.

Willie Ingram (M.S. Psychology), along with Priscilla Metoyer (MSW), and Denalla Ausborn (M.S. Psychology) evaluated E.W. and concluded that she was a very challenging patient. They agreed with me that the mental retardation component of her diagnosis did not appear to be the area requiring focused treatment, but rather their personality disorder. (Doc. No. 9439) Similarly, Dr. DeBacher concluded that E.W.'s behavior problems appeared mainly related to her borderline personality structure and to her depression and not to insufficient retardation services.

19.

A special staffing was held on April 19, 1995, to discuss these matters. (Doc. No. 9138) It was determined that E.W. would continue her hospitalization at GRH-A with the staff working with her on treatment goal #6, noncompliance with placement, and with additional efforts by Dr. DeBacher. (Doc. No. 9138)

20.

We continued to treat E.W. in the hospital. In addition to her mental problems, E.W. also had some serious physical problems, at times including urinary incontinence, bladder and renal problems of unknown cause, significant weight loss and dehydration through refusal to eat, balance problems, and others. These have at times required testing, treatment and close monitoring, as well as treatment at Grady Hospital. I have followed these

problems myself and consulted with other physicians and specialists as required. Testing, treatment and monitoring have all been made more difficult due to E.W.'s refusal to comply at various times.

21.

E.W. has a complicated psychopathology which makes her diagnosis difficult and controversial. For example, during this admission Dr. DeBacher evaluated her and his conclusion was different from mine. I also reviewed Dr. Elliott's evaluation, and his report included a diagnosis different from both myself and Dr. DeBacher. As stated previously in this affidavit, she also had other diagnoses at other times in the past.

22.

In my treatment of E.W. I first attempted the treatment methods described above, which are professionally acceptable and which have proved successful with other patients with similar problems. I also attempted to discharge E.W. to the community to personal care homes, where other patients with similar problems have been successful.

23.

When E.W.'s mental condition did not significantly improve and when she repeatedly was returned from placement in personal care homes, I consulted with other professionals at the hospital who suggested additional

professionally acceptable choices for treatment. Her treatment plan was adjusted at various times to try to address her problems.

24.

For example, in June 1995 an additional psychology component was added (Doc. No. 8682) and later a behavior management plan was implemented. That plan was developed by a behavior specialist who has worked with the mentally retarded population. (Doc. Nos. 8929 - 8932) E.W.'s mental condition and her behavior improved slowly and she has become more compliant with treatment. These improvements make it more likely that she would be able to be successful in the community.

25.

The treatment which has been provided at GRH-A has been adequate to ensure her safety and avoid unnecessary restraint. Since December 20, 1994, E.W. has been placed in seclusion twenty-three (23) times to protect herself and others, for aggressive and hostile behavior such as hitting, kicking, and attacking staff and throwing objects around other patients. On three (3) occasions she was also restrained for a short period of time for unsafe behavior. However, she has been secluded or restrained only to assure safety, and her treatment has been designed and provided to avoid unnecessary restraint or seclusion. (Doc. Nos. 8955-8969 & attachment A)

26.

A few months ago, I decided and the treatment team agreed that E.W. had sufficiently improved so that it would possible [sic] to discharge her to a nursing home if she continued to improve. In my opinion she would require the level of care of a nursing home due to her medical problems. The staff began looking for a nursing home which would accept her. However, in July E.W. was transferred out of my Unit due to a reorganization within the hospital and I am no longer her physician.

27.

In my opinion, E.W.'s treatment at GRH-A since I have treated her has always been appropriate to her needs. Generally, it is appropriate to treat a patient with E.W.'s level of severity of problems in a hospital such as GRH-A. Specifically, during the time that E.W. has been in the hospital while I have been treating her, it has been appropriate and professionally acceptable for her to be here and she has received adequate and appropriate treatment.

28.

By reason of my training, education and experience I am competent to make that treatment decision I made for E.W. In every decision I made regarding the treatment of E.W. I exercised my professional judgment and made professionally acceptable choices.

Further Affiant Sayeth Not.

This 21 day of August, 1996.

/s/ Dilipkumar Patel
DILIPKUMAR PATEL

Sworn to and subscribed
before me this 21 day
of August, 1996.

/s/ Martha Sue Davis
NOTARY PUBLIC

My commission expires:

Notary Public, Clayton County, Georgia
My Commission Expires July 27, 1999

**IN THE UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF GEORGIA
ATLANTA DIVISION**

[Caption Omitted In Printing]

AFFIDAVIT OF EARNESTINE PITTMAN

Comes now Earnestine Pittman who after being
sworn was deposed and said:

1.

My name is Earnestine Pittman. I am over the age of majority and am suffering from no disability which would render me incompetent to give this affidavit. I make this affidavit based upon my own personal knowledge and the documents referenced herein, for use in Defendants' motion for summary judgment which I understand is being filed with the Court.

2.

I am the Director of the Fulton County Regional Board. The Regional Board is responsible for establishing policy and direction for disability services planning, delivery, and evaluation within Fulton County, O.C.G.A. § 37-2-5(a), which is E.W.'s region.

3.

Under what is commonly referred to as "House Bill 100" all funding for community mental retardation services is directed from the Division of Mental Health, Mental Retardation, and Substance Abuse in the Department of Human Resources to the regional boards.

4.

The regional boards are also authorized by the legislature to access funds which are appropriated by the legislature to the Department of Medical Assistance (DMA), for matching federal funds from Medicaid for providing community mental retardation services. These are used to create Medicaid waiver slots, meaning that the region is authorized to serve persons with mental retardation services in the community under the Medicaid waiver program.

5.

The Medicaid waiver program is a primary funding source in Fulton County for community residential services for persons with mental retardation.

6.

The Fulton County Regional Board does not currently have any uncommitted Medicaid waiver funding available and therefore cannot provide these services to E.W. under that program. The funding which was appropriated by the legislature to DMA for the Medicaid waiver program for the Board is being used to provide services for other disabled persons.

7.

The Board does not currently have sufficient annualized unallocated state funds available to provide community residential mental retardation services to E.W. The state funds which have been appropriated to the Board for community retardation services are being used to provide services for other disabled persons.

8.

The Board, through its Comprehensive Evaluation Team (CET), is responsible for recommending the consumers who may be served under the Medicaid waiver program in the county. The CET is composed of persons with special training and experience in the assessment of needs and provision of services for mentally retarded person.

9.

The CET evaluated E.W. in March of this year and recommended against moving her from Georgia Regional Hospital at Atlanta into the community. The Psychological Evaluation and Social Work Assessment making this recommendation are attached. Since, as stated above, funding is not available, the CET's recommendation did not affect whether services were provided to E.W.

FURTHER AFFIANT SAYETH NOT.

/s/ Earnestine Pittman
EARNESTINE PITTMAN
Director, Fulton County
Regional Board

Sworn to and subscribed
before me this 21 day
of August, 1996.

/s/ Stephanie Mitchell
NOTARY PUBLIC

My commission expires:

Notary Public DeKalb County, Georgia
My Commission Expires August 18, 1998

Progress Notes
Patient Identification
E.W.

Date: 5/17/96

Time: 6:15 p.m.

Disc.: SW

S/S#: 5

* * *

Notes: Talked with Gloria Shepherd, Fulton Cty Regional Board, who states no placement is available at this time but she is aware of pt. need for placement and she was referring pt. to United Cerebral Pasley [sic] for placement and she will cont to work on day tx & placement.

B. Ligon

* * *

Date: 6/10/96

Time: 3:15 p.m.

Disc.: SW

Re: E.W.

Notes: Social Service
Received a call from Gloria Shepherd who stated no new news on replacement for E.W. She referred pt. to UCP for placement and agreed that she will contact them for an update then notify me.

B. Ligon

* * *

Date: 7/17/96

Re: E.W.

Notes: was referred to Fulton Cty Regional Board for MR Services seeking day TX and MR placement. G. Shepherd FCRB, referred pt. to United Cerebral Palsy for placement with no progress at last contact. Attempted to reach her for an update. Unable to make connection at this time.

B. Ligon

* * *

Date: 8-1-96

Time: 8:00 a.m.

Disc.: SW

Re: E.W.

Notes: Ms. Ligon reported that patient was on waiting list for a Medicaid Waiver Bed. It's unknown how long it will be to get that bed. Ms. Ligon also discussed the status of the referral for placement, at United Cerebral Palsy. She's also on waiting list there.

* * *

IN THE UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF GEORGIA
ATLANTA DIVISION

Excerpt from Defendants' Response to Plaintiffs' Motion
for Summary Judgment, R65, p. 3

* * * *

Defendants . . . agreed. . . . that Intervenor may be able to show that she is eligible for at least some of the community programs which she seeks. . . . Defendants also agree that Plaintiff L.C. is eligible for at least some of the community programs which she seeks.

* * * *

IN THE UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF GEORGIA
ATLANTA DIVISION

AFFIDAVIT OF ALLEN FUTRAL, M.D.

Personally appeared before me the undersigned who, after being sworn by an officer authorized to administer oaths, herein deposes and says:

1.

I, Allen Futral, M.D., am over the age of 18 and suffer from no disability which affects my ability to testify in this matter. I give this affidavit based on my personal knowledge, my review of the medical records of Elaine Wilson and my own training and experience in the field of urology.

2.

I am a medical doctor. I received my M.D. from the University of Virginia in May, 1991. I am currently a sixth year surgical resident in Urology at the Emory University School of Medicine and the Chief Resident in the Urology Service at Grady. I am supervised by Thomas Keane, M.D. I am presently assigned to the Urology Service at Grady Memorial Hospital, one of the teaching hospitals affiliated with the Emory University School of Medicine.

3.

As a resident my duties include the evaluation and treatment of patients with urological diagnoses at Grady Hospital through its affiliation with Emory University.

4.

I am the principal physician responsible for the care and treatment of Elaine Wilson at Grady Memorial Hospital. I practice under the supervision of Orlando Lopez, M.D. and Thomas Keane, M.D., who are the attending urologists for all Grady urology patients. Ms. Wilson has been having problems with proper urine flow from her bladder. On February 19, 1997, I performed a surgical procedure to permanently divert the flow of urine away from the urinary bladder and toward an external opening created on Ms. Wilson's abdomen. This surgical procedure is known as the creating of an ileo conduit. I have managed Ms. Wilson's post-operative care following surgery.

5.

In the course of my medical training and urology residency, I have performed or assisted in the performance of approximately 30 surgeries to create permanent urinary diversions, that is, ileo conduit surgeries such as the one performed for Ms. Wilson on February 19th, 1997. The purpose of such a procedure is to divert urine from the urinary bladder. Under normal circumstances, a tube, known as the ureter carries urine made in the kidney to the bladder where it is retained until the bladder is emptied during voiding. In the creation of an ileo conduit, the ureter is brought out onto the external abdomen through an opening surgically created using a piece of bowel as a conduit. This provides a permanent diversion of urine to the skin through a stoma.

6.

After surgery to create an ileo conduit, urine flows through the ureter and exits the body through the stoma. This urine is captured in a plastic bag which has an adhesive backing which sticks to the skin of the external abdomen. The bottom of the bag has an open and close valve so that urine may be emptied routinely without removing the bag from the abdomen. The bag is worn directly on the abdomen beneath clothing. Generally, the bag is emptied into the toilet and patients treat this function as if it were the same as normal voiding.

7.

Post-hospital care for an ileo conduit is relatively simple. Typically, the ileo conduit bag is changed once per week and the urine bag is emptied from the bag several times a day. The bags are disposable and not reused. Care of the stoma entails washing around the surrounding skin with soap and water and assuring that the skin is dry before a new bag is attached.

8.

In Ms. Wilson's case, the problem with urine flow from the bladder was treated by catheterization for at least twelve months until August, 1996. Catheterization is a process whereby urine is removed from the bladder several times a day by inserting a tube into the bladder through the urethra and this kind of care requires more professional attention than does management of an ileo conduit. However, catheterization is usually handled on

an outpatient basis and would not require hospitalization or institutional care.

9.

Ms. Wilson was admitted to Grady Memorial Hospital with compromised kidney functioning in August, 1996, and nephrostomy tubes were inserted as a temporary measure to improve her kidney function. These tubes removed urine from the body much the same way as the ileo conduit. The tubes, because of the risk of infection at the point of entry through the back into the body, require more care and attention than a permanent ileo conduit. Prior to Ms. Wilson's release from her current admission to Grady Hospital, the nephrostomy tubes will be removed and the areas where the tubes were inserted will begin to heal over, although they should be watched for any signs of infection until completely healed. The only medical attention involved would be to change the dressing once a day during the healing process which lasts about a week after discharge.

10.

Ms. Wilson's ileo conduit surgery was successfully completed and her post-operative course has not presented any unusual problems. Her post-operative care is anticipated to require 10-20 days of hospitalization, a period of time which would enable her to become familiar with care of the stoma and the regular emptying and replacement of the plastic urine bag.

11.

During the 9 days that I have recently observed Ms. Wilson, as her recovery progresses, she has been alert, cooperative, and cheerful.

12.

Care of the ileo conduit is routine for most patients and does not require professional medical intervention. Typically, patients learn how to empty and replace the bags themselves. Most patients perform their own care of the stoma. Persons with no medical training can easily be taught how to clean the stoma, apply the bag, and empty the urine from the bag. Patients with limited mental abilities can be taught to perform self-care. In light of Ms. Wilson's mental retardation, this intervention was chosen so that management of the urinary diversion would be as simple as possible. The literature and my experience would support this as the best approach to maximize Ms. Wilson's independence and to minimize long-term complications.

13.

In Ms. Wilson's case, I would recommend that she have supervision in caring for the stoma and changing the bag until she is fully capable and comfortable with the process. This supervision and assistance does not have to be provided by nursing personnel. Based on my contact with Ms. Wilson, there is no indication that she is unable to learn how to self-manage her ileo conduit care.

One of the goals of the surgery was to assist Ms. Wilson in maximizing her ability to engage in a more normal life.

14.

Although Ms. Wilson will require outpatient medical monitoring of her ileo conduit and renal condition and attention to her anemia after she is discharged from Grady, the degree of care would not require nursing home or other institutional care. It is the experience of most patients that an ileo conduit does not significantly interfere with their ability to lead a normal life.

15.

There are no plans for further surgical treatments for Ms. Wilson at Grady Hospital. All her urological needs could be met in a community setting. Any necessary monitoring of her condition could be done in a community setting. From a urological standpoint, it is my opinion that she can readily be treated in a community setting and I would not hesitate to release her to such a placement if one were available.

Further affiant sayeth not.

/s/ Allen Futral, M.D.
ALLEN FUTRAL, M.D.

Sworn to and subscribed
before me this 27th
day of Feb., 1997.

Notary Public, DeKalb County, Georgia
My Commission Expires June 11, 1999

/s/ Albert R. Spearman
NOTARY PUBLIC

IN THE UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF GEORGIA
ATLANTA DIVISION

AFFIDAVIT OF DIANE COBB

Comes now before me the undersigned, who, being duly sworn, deposes and says:

1.

I, Diane Cobb, am over the age of 18 and competent to make the statements. Each is based on my personal knowledge and observations of Elaine Wilson and her circumstances, my clinical training and experience, particularly in the areas of mental health and mental retardation, and my experience as a provider of community residential services to mentally disabled adults.

2.

I am a registered nurse, licensed to practice in Georgia since 1973. I received my nursing degree from Manhattan College, New York City, New York, in 1972 and have been a practicing nurse for 24 years. My nursing career has been principally in the area of mental retardation, providing a combination of nursing and habilitation services to persons with mental retardation.

3.

Currently, and for the past 2 years, I have been a provider of community-based residential programs for mentally disabled adults, including a "personal support"

program for a mentally retarded adult through the Mental Retardation Waiver Program, a program designed to provide services in the community to persons who would otherwise be institutionalized or at risk of institutionalization. In addition to the provision of community services as a private provider, I am also a consultant with the DeKalb County Community Service Board (CSB), a public provider of mental health and mental retardation services. In this capacity, I train CSB staff, provide nursing services to clients, and follow-up care for physicians. I have also provided training to other home providers as an independent consultant.

4.

Prior to my current activities, I worked extensively with the developmentally disabled, mentally retarded, and physically handicapped as a nurse for 18 years, including seven and one-half years at the Stillwater Health Center, an institution for persons with mental retardation in Dayton, Ohio, 4 years at a similar institution in Willowbrook, New York, and 5 years at the Developmental Learning Center, a residential institution for the mentally retarded adults at Georgia Regional Hospital at Atlanta (GRH-A). During the period that I worked at the Developmental Learning Center, from 1985 to 1989, I was involved in the development of numerous transitional plans for persons who moved from the institution to the community as the result of a lawsuit.

5.

Typically, the habilitation plans for people moving out of institutions into the community address three areas: training/habilitation, behavioral problems, and medical problems.

6.

In my experience with the habilitation of mentally retarded and mentally ill adults in community settings, medical problems and needs are approached the same way such problems and needs would be addressed for anyone with a similar problem, that is with appropriate medical oversight on an outpatient basis, including home health services, if necessary. If a medical emergency arises, appropriate emergency medical services are utilized.

7.

Persons with mental retardation have a variety of medical needs requiring daily monitoring, such as feeding tubes, catheters, colostomies, dialysis, high blood pressure and other conditions that affect the general population. All of these conditions can be successfully managed in a community residential program.

8.

In many instances, it is easier to provide medical services to a person who is resistant or who has limited understanding in a community rather than an institutional setting because it is a calmer environment, there is

more individualized attention, and much greater flexibility for staff, who are experienced in working with the mentally retarded, to find successful ways to encourage and support the individual. For example, if a person is uncooperative with treatment or in a negative mood, it is easier in a home-like community residential setting to simply wait for an opportunity at another time.

9.

I am acquainted with Elaine Wilson. When I was a nurse at GRH-A, I had occasion to work on all the units and Ms. Wilson was frequently admitted during those years in the late 1980s. More recently, I visited her at GRH-A on October 19, 1996, when she was on the "East" unit. On that occasion, I spoke to her for about an hour, spoke informally to staff on the unit, and reviewed her record, including admission notes and progress notes before and after she was hospitalized at Grady Memorial Hospital in August, 1996. I was focusing particularly at that time on any medical problems to determine whether they could be met in a community setting.

10.

On the day that I met with Ms. Wilson, she had bilateral nephrostomy tubes. The tubes were filtering properly, there was no sign of infection, and she was in no immediate distress or pain. It was my understanding at that time that she anticipated surgery to replace the tubes with a permanent ileo conduit. I did not see any great difficulty in meeting Ms. Wilson's medical needs in a home or community setting through the medicaid waiver

personal support program, enlisting the assistance of home health aids.

11.

Ms. Wilson, in my view, would greatly benefit from habilitation activities designed to develop and regain her abilities to function independently. These activities would include cooking, shopping, home maintenance, public transportation, socialization skills, and many other activities related to the normal activities of life in a community setting.

12.

In my view, Ms. Wilson's behavior problems are likely to decrease significantly or disappear in a structured community residential program because they seem to be directly related to her need for individualized attention and productive activity. In my experience, persons with mental retardation and mental illness, especially if they have been frequently institutionalized, often have long-standing behavior problems which can be more effectively addressed in the community where the individual can form a consistent relationship with one or two trained staff in a supportive environment.

13.

Since my visit with and assessment of Ms. Wilson in October, 1996, I have been advised that she had ileo conduit surgery. I am familiar with the care of a person with an ileo conduit, that is, the routine emptying of the

bag on a daily basis and the regular replacement of the bag which is usually done once a week. This is routine care that many people handle without assistance and Ms. Wilson may, in time, learn to self-manage her care. Care of an ileo conduit does not require placement in a hospital, nursing home, or other institutional setting.

14.

I am willing and able to serve Ms. Wilson in the community in a personal support and habilitation program with 24-hour supervision, including whatever nursing care is required. I am aware that Ms. Wilson must be routinely monitored for signs of renal failure, anemia, and high blood pressure and that her personal support team would need to be trained to identify these signs.

15.

As is the case with all mentally disabled persons served in residential community programs, including my programs, Ms. Wilson will need a comprehensive individualized service plan which would cover her habilitation and medical needs and how these needs would be met through a variety of day training, outpatient, emergency, case management, and crisis intervention services.

16.

It is my opinion that Ms. Wilson is not a particularly challenging person to serve in a community setting with

adequately trained staff, structured activities, and sufficient opportunities for her to enhance and increase her independent living skills.

Further affiant sayeth not.

/s/ Diane Cobb
DIANE COBB

Sworn to and subscribed
before me this 25
day of Feb., 1997.

Notary Public, DeKalb County, Georgia
My Commission Expires June 11, 1999

/s/ Albert R. Spearman
NOTARY PUBLIC

THE UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF GEORGIA
ATLANTA DIVISION

[Caption Omitted In Printing]

AFFIDAVIT OF CARL E. ROLAND, JR.

* * *

1.

I, CARL E. ROLAND, JR., am over 18 years old and base these statements on my personal knowledge of the matters discussed in this affidavit.

2.

I serve as the Director of the Division of Mental Health, Mental Retardation, and Substance Abuse of the Department of Human Resources for the State of Georgia. As such, I administer and supervise the State programs for mental health, mental retardation, and substance abuse, and I direct, supervise, and coordinate the State's provision of facility-based services for Georgia residents with the conditions of mental illness, mental retardation, or substance abuse, or with combinations of these conditions. The Division and the Director's position are established and governed by statute, e.g., O.C.G.A. § 37-1-20.

3.

The defendants currently have no funds with which to implement the Court's order for adding a community placement for E.W. To secure these funds, they will have no recourse but to terminate or reduce State services to one or more other persons already being served, or to

delay services to other facility-based persons. My understanding from professional staff is that E.W. is receiving at least minimally adequate care in her present placement for her current requirements.

4.

More specifically, funds for E.W.'s community placement would have to come from the Fulton County Regional Board, in accordance with O.C.G.A. §§ 37-2-5.1(c), 37-2-5.2(a)(2). The director of that Board, Earnestine Pittman, has already stated in an affidavit that the Board (1) "does not currently have any uncommitted Medicaid waiver funding available" and (2) "does not currently have sufficient annualized unallocated state funds available to provide community residential mental retardation services to E.W." In addition, the Fulton Regional Board, as does each of the other eighteen Boards, has begun to maintain an extensive waiting list of individuals who are seeking but are not receiving facility-based or community-based services.

5.

There are no other funds currently available. First, the remainder of the current appropriation received by the Division from the General Assembly has been allocated to the other Regional Boards to fund the operation of their programs, as authorized by O.C.G.A. § 37-1-20(b)(8). Second, the "discretionary fund" of \$300,000 mentioned several times by the plaintiffs in their documents in this case was intended for providing emergency placements, and it was completely expended long

ago. Third, the Department of Medical Assistance for the State of Georgia has required that all new "Medicaid waiver" funds be used to provide community placements for residents in ICF/MR State facilities such as Brook Run, whose closing was directed by the General Assembly in the Session that just ended. This position is stated in the letter of Marjorie P. Smith, Commissioner, to Gail W. Reed (Jan. 16, 1997), in Ex. 11 of "Plaintiffs' Response to Defendants' Supplemental Brief in Support of Defendants' Motion for Summary Judgment and in Opposition to Plaintiffs' Motion for Summary Judgment" (served Mar. 3, 1997).

6.

Finally, although the Division is authorized to move funds between facility-based programs and community-based programs, such a transfer must be accomplished in compliance with the provisions of the Appropriations Act and other applicable laws, according to O.C.G.A. § 37-2-5.1(c)(3). The Division is charged by law (e.g., O.C.G.A. § 37-1-20) with establishing and maintaining both community placements and institutional placements. It cannot comply with its duty to provide adequate facility programs if it moves any more of its facility funds to community programs.

7.

The only way in which E.W.'s community placement can be funded at this time is by terminating or reducing State services for a person or persons now receiving them. As an administrator and as a human being, I do not

find this to be a satisfactory alternative, particularly when it is used on an interim basis pending appeal.

8.

I have read the Court's opinion, and I interpret it to mean that since E.W. can be treated in the community, she *must* be treated there. Many administrators and professionals in this field, including myself, believe that virtually anyone *can* be treated in the community, given unlimited funds, personnel, and other support. This does not mean, though, that persons can *not* be treated in a facility, or that they do not need facility-based care, or that it is always better to treat them in the community. The State has legitimate interests in maintaining facility-based programs as part of its spectrum of care.

9.

I think that many persons currently receiving care in our facilities will believe, just as E.W. believes, that they can be treated in the community. I predict that many of their representatives will seek community placements for them by filing lawsuits against the State like this one, if the decision in this case is not stayed. Based on our experience with other litigation, I know that a large number of lawsuits will drain substantial amounts of time, energy, and money from the Division and will significantly impede its work in providing care.

10.

Placing just E.W. herself in the community now, if this decision is not stayed, would entail substantial expense. The projected annualized cost of L.C.'s community placement was \$88,455, and E.W. has substantially greater needs than L.C.

11.

Requiring immediate placement of E.W. in the community, if the Court's decision is not stayed, would deprive the Division and the Regional Boards of their lawful authority to exercise their professional expertise and discretion in making treatment decisions. The Division and the Regional Boards are required to make very difficult decisions in distributing the appropriated funds to achieve maximum benefit and balance the needs of many eligible recipients of public services.

12.

Despite the plaintiffs' allegations to the contrary, the Division has used its discretion to downsize facility programs and expand community services. The Division planned and implemented the closing of Rivers Crossing, an Athens, Georgia, unit of Brook Run, in 1996. In this process, all beds at the facility were closed, and 36 children and young adults were moved to well planned and funded community placements.

The Division, in cooperation with some of its Regional Boards, closed two mental retardation units at Bainbridge State Hospital, Bainbridge, Georgia, which

permitted 27 individuals to live in the community. In addition, the number of persons added in home and community based Medicaid waiver slots from the fiscal year 1991 to the present has increased by 1,919 persons. This includes a number of consumers who have never received services, as well as providing a more comprehensive set of services to better meet the needs of existing consumers. The waiver has allowed the State to make more efficient use of limited state funds by matching them with federal dollars.

The Division also committed to closing Brook Run itself, and the General Assembly has now directed that closure to be accomplished by December 31 of this year. As a consequence, 326 persons will be moved from facility settings to community placements by that date.

13.

The granting of a stay of the Court's decision pending appeal will permit the Division and the Regional Boards to avoid disruptions to other persons' services during the appeal, and it will allow planning and implementation of large-scale changes in the delivery of services, if necessary, based upon a final appellate decision.

Further affiant sayeth not.

/s/ Carl E. Roland, Jr.
CARL E. ROLAND, JR.

Sworn to and subscribed
before me this 17 day
of April, 1997.

/s/ Rosemary Murphy
NOTARY PUBLIC

Notary Public, Fulton County, Georgia
My Commission Expires Oct. 18, 1997

[SEAL]

IN THE UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF GEORGIA
ATLANTA DIVISION

[Caption Omitted In Printing]

AFFIDAVIT OF PHILLIP A. HORTON, M.D.

* * *

1.

I, PHILLIP A. HORTON, M.D., am over 18 years old and base these statements on my personal clinical evaluation of E.W., my review of pertinent portions of her medical chart, and my discussions with her current caregivers.

2.

I am licensed to practice medicine and surgery in the state of Georgia. I received my medical degree from the Medical College of Georgia in 1986. Subsequently I completed two residency programs at Medical College: the first, in internal medicine, from 1986 to 1989, and the second, in psychiatry, from 1989 to 1992. I am Board-certified in both of these specialties.

3.

Since 1992, I have served as psychiatrist and internist on a geriatric unit at Georgia Regional Hospital/Augusta, and then as Clinical Director at Georgia Regional Hospital/Savannah. Both of these State hospitals are primarily mental health facilities. I also served concurrently as

Assistant Clinical Professor in Psychiatry at Medical College from 1992 to 1995 current (P.H.) I have given continuing medical education presentations on "Medical Diseases that Present with Psychiatric Manifestations" and on "Use of Psychotropics with Consumers Dually Diagnosed MI/MR."

4.

I have served as Clinical Director at Gracewood State School and Hospital since May 1, 1996; that is my current position. Gracewood is a State facility for persons with mental retardation. The clients there range from those with mild retardation and no physical limitations to those profoundly retarded and requiring skilled medical care. Additionally, I currently serve as a captain in the Medical Corps, United States Army Reserve. In that part-time position I practice internal medicine exclusively.

5.

I consulted on E.W.'s case on April 1, 1997, and I completed my consultation report that same day. Attached to this affidavit and incorporated in it is a true and correct copy of that report. In the remainder of this affidavit, I will highlight the significant findings in my report.

6.

I saw E.W. at her current placement on the second floor of the Medical Surgical Hospital at Central State Hospital in Milledgeville. That floor operates as a nursing

facility within the Hospital. E.W. is a renal patient, and she is a person with mild to moderate mental retardation.

7.

E.W. has fairly serious problems related to her renal status. One of her current medical diagnoses is azotemia, which is the presence of urea or other nitrogenous bodies in the blood. Her most recent lab work shows, for example, a BUN (blood urea nitrogen) reading four times the normal amount, and a creatine reading three times normal. For this reason I have concluded in the Discussion part of my report that E.W. "requires intense medical monitoring of her current renal functioning, including: daily fluid Input and Output on all shifts, daily protein intake, daily weights, caloric counts, periodic electrolyte and renal monitoring." Her renal status, along with her continuing to heal after her recent surgery, is the reason that she is "too weak for most independent activities of daily living and therefore requires assistance (bathing, walking, toileting, eating, etc.)," as I noted in the report.

8.

Another serious problem is that E.W. is colonized with Vancomycin Resistant Enterococcus. That organism is bacteria of the human intestine for which there is no known antibiotic. To be "colonized" means that she is carrying it as a resident. It can spread to others, particularly others who are debilitated. Managing its effects requires, as I note in my report, "scrupulous sanitary

conditions," and "[i]t is unlikely this could be done anywhere other than a hospital or nursing home." This problem may well be exacerbated, as I noted, by the fact that "[d]espite an ileal conduit, the client continues to have urinary incontinence, wetting her undergarments. . . ."

9.

For the present, E.W. requires continued care in a nursing facility. I am unable to state at this time, to a reasonable medical certainty, how long she will need to remain there. She will continue to be treated and monitored for improvement.

Further affiant sayeth not.

/s/ Phillip A. Horton, M.D.
PHILLIP A. HORTON, M.D.

Notary Public, Richmond County, Georgia
My Commission Expires, Aug. 19, 2000

/s/ Ann W. Copiland
NOTARY PUBLIC

Sworn and subscribed before me
this 8th day of April, 1997.

CENTRAL STATE HOSPITAL

CONSULTATION SHEET

QUEST - PARTS I, II AND III MUST BE COMPLETED BY
REQUESTING PHYSICIAN

/s/ Dr. Gill FROM: /s/ GL Echols Md

DATE OF REQUEST: 3/10/97

REASON FOR REQUEST & PROVISIONAL DIAGNOSIS:

*Follow up consultation to render current opinion of psychiatric
& M.R. status with most likely diagnosis (-es). Please see
attached info.*

Thanks, GLE

RECEIVING FOLLOWING DRUGS:

- | | |
|---------------------|------------------|
| 1. <u>Depakote</u> | 2. <u>Zoloft</u> |
| 3. <u>Risperdal</u> | 4. _____ |
| 5. <u>Klonopin</u> | 6. _____ |

PSYCHIATRIC SUMMARY:

DEBTOR'S SIGNATURE PLACE OF CONSULTATION

☐ BEDSIDE

☐ EMERGENCY

☐ ON CALL

☐ ROUTINE

NATURE AND TITLE

E.W.

/s/ L Gill MD 618

3/11/97

March 11, 1997 CONSULTATION REPORT E.W.

The patient was interviewed in her room and her chart was reviewed. Her psychiatric assessment is as follows:

1. Is she currently mentally ill, that is, having a disorder of thought or mood which significantly impairs judgement, behavior, capacity to recognize reality or ability to cope with the ordinary demands of life?

This patient appears to be in remission of what appears to be a chronic schizophrenic illness, paranoid type. She currently has no significant symptoms or any delusional thinking and is under fair remission with the antipsychotic Risperdal. She has good reality testing and appears to be able to cope with the ordinary demands of life.

2. Does she represent a substantial risk of imminent harm to herself or others?

This patient does not appear to pose a significant or substantial risk to herself or others. She has no such ideations and has made no such gestures.

3. Is this facility a least restrictive treatment setting that is available?

This patient could possibly be managed in a less restrictive setting with the appropriate medical and psychiatric follow up.

VOLUNTARY INPATIENT CARE:

- A. Does patient presently meet each of the standards established for such care, that is, does she show evidence of mental illness and is she suitable for treatment? The patient has occasional auditory hallucinations and appears to be in remission of most of her psychiatric symptoms at this time. She, however,

needs continuing psychiatric treatment to avoid relapse of her psychiatric illness and therefore meets the criteria for continuing treatment.

- B. Is patient competent to seek voluntary admission to a facility? The patient is competent to seek voluntary admission.
- C. If she is competent, is she requesting voluntary admission? She has not made that request at this time.
- D. Does E.W. meet each of the standards for involuntary outpatient treatment, that is, is she mentally ill? No.
- E. Based on a treatment history or current mental status will she require outpatient treatment in order to avoid predictably and eminently becoming an inpatient? Yes.
- F. Because of her current mental status, mental history or nature of her mental illness, is she unable voluntarily to seek or comply with outpatient treatment? No. I feel that she can voluntarily comply with outpatient treatment.
- G. Is she in need of involuntary treatment? No, not at this time.
- H. Is outpatient treatment the least restrictive treatment setting available to E.W. within the limits of State funds, specifically appropriated therefore? Yes.
- I. Does E.W. meet each of the standards for voluntary outpatient treatment, that is, does she show signs of mental illness? Yes.
- J. Is she suitable for treatment? Yes.
- K. Is she now clinically competent to seek community mental health services voluntarily? Yes.

- L. If she is competent, is she requesting voluntary use of community mental health services? Yes.

DIAGNOSIS:

- Axis I: Schizophrenia, chronic, paranoid type (in remission).
- Axis II: Borderline intellectual functioning, rule out personality disorder, not otherwise specified.
- Axis III: Chronic renal failure with ileal diversion of urinary tract.
- Axis IV: Moderate.

* * *

IN THE UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF GEORGIA
ATLANTA DIVISION

AFFIDAVIT OF RICHARD ACKERMAN, M.D.

1.

My name is Richard J. Ackerman, M.D. I am an adult and competent to attest to the statements in this affidavit. I am a board-certified physician and geriatrician who teaches full time in the medical school at Mercer University. I am experienced in and familiar with the capabilities of community services and nursing homes.

2.

At the request of Susan C. Jamieson, staff attorney at the Atlanta Legal Aid Society, I reviewed the medical records and certain other documents, including the April 1, 1997, evaluation of Dr. Horton, regarding E.W. covering the period from March 3, 1997, through April 16, 1997, in order to address two of E.W.'s medical problems: (1) vancomycin - resistant enterococcal colonization of the stool (VRE) and (2) a sacral pressure sore. I was asked to assess, based on the medical records provided by Ms. Jamieson, whether E.W., because of either the VRE or the sacral pressure sore, required hospital or nursing home placement. I prepared a two page report, dated April 30, 1997.

3.

Attached to this April 30, 1997, report is an accurate copy of my Curriculum Vitae.

4.

The conclusion that I reached is that neither VRE nor the sacral pressure sore would provide an obstacle to community-based care for this individual. To the contrary, I believe that hospitalization or nursing home placement could even worsen her condition.

5.

VRE is an organism that is common in hospitals and E.W. probably acquired it during one of her many hospitalizations. Its presence is currently of only incidental significance and good handwashing is all that is required. Pressure sores are the result of immobility. In E.W.'s case, I consider the most important cause of her skin breakdown to be excessive sedation. E.W.'s medical records indicate that the Central State neurologist shares my view that she was over-sedated in his consult on March 22, 1997.

6.

I specifically disagree with Dr. Horton's conclusion that E.W. requires "a closely medically supervised setting such as a hospital or nursing home." On the contrary, despite her medical and psychiatric disabilities, E.W. would be well served by outpatient community medical care.

7.

I have set forth the bases for my conclusions in greater detail in my April 30, 1997, report, attached to this affidavit.

/s/ Richard J. Ackerman
RICHARD J. ACKERMAN

[SEAL]

/s/ Peggy W. Taylor

Sworn to and subscribed
before me this 1st day
of May, 1997.

MY COMMISSION EXPIRES APRIL 18, 2000

IN THE UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF GEORGIA
ATLANTA DIVISION

[Caption Omitted In Printing]

SECOND AFFIDAVIT OF EARNESTINE PITTMAN

* * *

1.

My name is Earnestine Pittman. I am the same Earnestine Pittman who signed an affidavit in this case on August 21, 1996. I am over the age of majority and am suffering from no disability which would render me incompetent to give this affidavit. I make this affidavit based upon my own personal knowledge and the documents referenced herein, for use by the Defendants.

2.

I continue to serve as the Director of the Fulton County Regional Board, as I did when I signed the previous affidavit. The Regional Board is responsible for establishing policy and direction for disability services planning, delivery, and evaluation within Fulton County, O.C.G.A. § 37-2-5(a), which is E.W.'s region.

3.

I have reviewed my previous affidavit. The funding situation described there has changed to some extent, so that the Board may be able to access public funding that was unavailable to E.W. at the time of that affidavit.

4.

E.W.'s psychiatric and physical condition has also changed to some extent since then, according to reports. for that reason, the Board is initiating a re-evaluation of E.W. at this time.

5.

If E.W. is found to satisfy standards for community placement under Georgia law, public funding will be pursued and she will be considered for such placement in the same manner as other persons similarly situated are considered.

6.

As a result of this re-evaluation, E.W. may thus obtain a publicly funded community placement on the basis of Georgia law, the normal workings of the public health system founded on that law, and the normal operation of the Regional Board.

/s/ Earnestine Pittman
EARNESTINE PITTMAN

Sworn to and subscribed
before me this 19th day
of May, 1997.

/s/ Illegible
NOTARY PUBLIC

My commission expires:

Notary Public, Fulton County, Georgia
My Commission Expires October 7, 2000

IN THE UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF GEORGIA
ATLANTA DIVISION

[Caption Omitted In Printing]

SECOND AFFIDAVIT OF PHILIP A. HORTON, M.D.

* * *

2.

On May 12, 1997, I again visited Central State Hospital in Milledgeville, Georgia, to assess the patient E.W. Attached to this affidavit is my report on that assessment. I based the statements in the report on my personal clinical evaluation of E.W., my review of pertinent portions of the medical chart, and my discussion with her current caregivers.

3.

As a summary of this report, it is fair to say that E.W. has shown clear improvement since my report of April 1, 1997, which was attached to my affidavit of April 7, 1997. Her present condition does not completely preclude her being placed in a community residential placement, as her condition did on April 1. The nature, timing, and funding of such a placement, if it can be devised, are matters best left to a team of health care professionals and administrators assigned to that task. They can formulate a very specific service plan and pursue funding for it.

4.

The critical importance of having a team of health care professionals and administrators continue to make careful decisions for E.W. is underscored by the growing controversy in the public health community about the relative costs and benefits of the "deinstitutionalization" movement that has taken place over the past three decades. I attach two articles illustrating more recent thought on this subject. The first, "Comparative Mortality of People with Mental Retardation in Institutions and the Community," finds that for persons with mental retardation who were studied for the article, the "[r]isk-adjusted odds on mortality were estimated to be 72% higher in the community than in institutions." In the second article, "Medical Disorders of Adults with Mental Retardation: A Population Study," the authors studied a group of adults with mental retardation and found that "[c]ompared to the local population, the study group had significantly increased cardiovascular risk factors, rate of medical consultation, rate of hospitalization, and mortality." Both of these articles appeared in the *American Journal on Mental Retardation*, a refereed journal that is a standard source and a reliable authority in this field. Both have generated controversy, but certainly both raise issues requiring careful consideration by health care professionals and administrators.

Further affiant sayeth not.

/s/ Philip A. Horton, M.D.
PHILIP A. HORTON, M.D.

(SEAL)

/s/ B.A. Stafford

NOTARY PUBLIC Comm. Expires 11-11-00

Sworn and subscribed before me

this 19th day of May, 1997.

In the United States Court of Appeals
for the Eleventh Circuit

DRAFT

Preliminary Plan

Not approved or Funded

PROJECTED SERVICE COST**Medicaid Waiver**

Personal Support	\$43,165.00
Service Coordination	\$17,010.00
Day Habilitation (Six months)	\$ 3,700.00
Medicaid Option	\$ 0.00
Total	\$63,875.00

Source: Region 5

Psychiatric Consultation

Local Mental Health Center	\$ 0.00
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Community Program

Day Treatment	\$ 7,200.00
Social Club	\$ 2,160.00
Total	\$ 9,360.00

<u>State Match to DMA</u>	\$19,365.00
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Total	\$92,600.00
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* These figures will need to be adjusted based on E.W.'s actual needs post discharge. Additionally, this does not constitute a guarantee that there will not be unforeseen cost barriers.

IN THE UNITED STATES COURT OF APPEALS
FOR THE ELEVENTH CIRCUIT

CASE NO. 97-8538

L.C. and E.W., each by JONATHAN ZIMRING,
as guardian ad litem and next friend,
Plaintiff and Intervenor-Appellees,

v.

TOMMY OLMSTEAD, Commissioner of the
Department of Human Resources;
RICHARD FIELDS, Superintendent of
Georgia Regional Hospital/Atlanta
and EARNESTINE PITTMAN,
Executive Director of the
Fulton County Regional Board,
all in their official capacities,
Defendants-Appellants.

ON APPEAL FROM THE UNITED STATES
DISTRICT COURT FOR THE NORTHERN DISTRICT
OF GEORGIA
CASE NO. 1:95-CV-1210-MHS

* * *

Excerpt from Petition for Rehearing and Suggestion of
Rehearing En Banc, p. 14:

* * * *

. . . . the "additional expenditures necessary to treat L.C.
and E.W." in the community are, by definition, not unrea-
sonable, nor could they "fundamentally alter" the ser-
vices provided by the State.

* * * *

* * *

IN THE UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF GEORGIA
ATLANTA DIVISION

L.C. and E.W. by JONATHAN ZIMRING
as guardian ad litem and next friend,

Plaintiff,

CIVIL ACTION

v.

FILE NO. 1:95-CV-1210

TOMMY OLMSTEAD, Director of
the Department of Human
Resources; RICHARD FIELDS,
Superintendent of Georgia
Regional Hospital at Atlanta;
and EARNESTINE PITTMAN,
Executive Director of the
Fulton County Regional Board,
all in their official capacities,

Defendants.

AFFIDAVIT OF DIANE COBB

STATE OF GEORGIA

COUNTY OF FULTON

Personally appeared the undersigned, who after
being duly sworn by an officer authorized to administer
oaths, deposes and says:

1. I am the operator of the Nyasha Hands (Loving
Hands) group home at 3442 Midway Road, Decatur, Ga.
The Nyasha Hands program provides 24-hour supervi-
sion and support by trained staff to persons with mental
retardation. Staff assist our 3 residents with independent
living skills, behavior management, and leisure activities
in a 4-bedroom home in a Decatur neighborhood.

2. L.C. and E.W. have both resided at Nyasha
Hands. L.C. arrived in February 1996 and E.W. in July
1997. L.C. still resides there.

3. E.W. moved on September 2, 1998, after 14
months with us, to a more independent supervised apart-
ment setting.

4. In my view, based on more than 20 years experi-
ence with the habilitation of persons with mental retarda-
tion, both L.C. and E.W. are doing well and progressing
steadily in a community setting, although they each have
challenging needs.

5. In this affidavit, I will set out what information is
available to me about the cost of L.C. and E.W.'s care in
the community during the time that each resided at
Nyasha Hands.

6. With regard to L.C., the cost of the personal care
and staff support provided through the Nyasha Hands
24-hour staff was not reimbursed at all during the first 7
months after her discharge from Brook Run into our care.
This would be approximately the period from February,
1996 through August, 1996.

7. In September, 1996, Nyasha Hands began receiv-
ing \$118.26 per day to cover the cost of the 24-hour
personal care and staff support provided to L.C.

8. In addition to the per diem payment for personal
support, an additional amount is available on weekdays
for day habilitation services and is paid directly to the
day habilitation provider. On information and belief, this
amount is \$70.00.

9. L.C. pays for her own room and board through her Social Security disability and Supplemental Security Income disability benefits, less a \$60.00 personal needs allowance. This amounts to a monthly payment of \$424.00 to Nyasha Hands.

10. L.C. also has a case manager through the "Access" program of the Fulton County Community Service Board, a mental health service. The case manager maintains regular contact with L.C. and has certain responsibilities managing L.C.'s community-based program. I am not aware of the dollar value of this service.

11. It is my understanding that the \$118.00 per diem and the day habilitation expenses are covered by the Mental Retardation Waiver Program and that the funds for these services are distributed through the Fulton County Regional Board. I believe that other expenses, such as regular medical care, mental health care, and case management services are covered through other sources, such as the "regular" Medicaid program operated through the Department of Medical Assistance.

12. Based on my own informal calculations, the annual cost to the State of L.C.'s community-based mental retardation services would be the state "match" for L.C.'s mental retardation waiver "slot" or approximately \$18,500.00.

13. With regard to E.W., upon her placement at Nyasha Hands in July, 1997, we received \$118.26 per diem to cover the cost of the 24-hour personal care and staff support provided to E.W.

14. In addition to the per diem payment, a certain amount has been available to cover the cost of E.W.'s day habilitation program at Health Care Foundations. I believe this amount is \$70.00 per day and that it is paid directly to the day habilitation service provider.

15. E.W. pays for her own room and board through her Supplemental Security Income disability benefits, less a \$60.00 personal needs allowance. This amounts to a monthly payment of \$424.00 to Nyasha Hands.

16. E.W. also has a "service coordinator" through the United Cerebral Palsy Organization. The cost of the coordinator is covered under the Mental Retardation Waiver. The cost of this service is \$140.00 per month.

17. It is my understanding that the \$118.26 per diem, the day habilitation expenses, and "service coordination" are covered by the Mental Retardation Waiver Program and that the funds for these services are distributed through the Fulton County Regional Board. I believe that other expenses, such as regular medical care and mental health care are covered through other sources, such as the "regular" Medicaid program operated through the Department of Medical Assistance.

18. It is my understanding that the annual cost to the State of E.W.'s community-based mental retardation services would be the state "match" (approximately one-third of the total) for L.C.'s Medicaid mental retardation waiver "slot". This is one-third of the per diem (\$118.26 for 365 days), the day habilitation (\$70.00 for 240 days) and the service coordination (\$140.00 for 12 months).

19. According to my calculations, the cost to the State in matching funds for E.W.'s Medicaid waver [sic] slot, based on the calculations in the above paragraph is approximately \$20,548.00 per year.

/s/ Diane Cobb
DIANE COBB

Sworn to and subscribed

before me this Sept.

day of 30th, 1998.

Notary Public, DeKalb County, Georgia
My Commission Expires November 17, 2000

/s/ Betty Jo Illegible
NOTARY PUBLIC

EVALUATION OF BROOK RUN A STATE MENTAL RETARDATION INSTITUTION

A Report Prepared by a Special Task Force
Appointed by the Privatization Commission

November 1996

* * *

GEORGIA BACKGROUND

In 1988, a study was conducted by O'Neal and Associates, Ltd. of the feasibility of closing the Georgia Retardation Center (later renamed Brook Run). The recommendation of the study was to close the facility and place the residents of the facility in community programs. The study was endorsed by the Board of the Department of Human Resources but the Plan was later withdrawn from consideration due to a number of concerns about the planning process and political opposition.

Also, in 1988 with the first submission to the Department of Medical Assistance of the HOME AND COMMUNITY BASED SERVICES WAIVER FOR MENTAL RETARDATION, Georgia began a strategy for reconfiguring the State's publicly funded services and supports for people with mental retardation. Broadly, these strategies called for reducing the role that institutional services played in meeting the needs of such individuals while concurrently expanding the scope and availability of community residential/support services. An obligation to reduce institutional beds by 1,000 by 1997 was established in the 1992 RENEWAL OF THE HOME AND COMMUNITY BASED SERVICES WAIVER FOR MENTAL RETARDATION. As of September 1996, only 147 of the

proposed 1000 bed reduction has been realized. The limited success has been due primarily to not having identified a concentrated closure of a large enough number of institutional beds needed to generate the necessary savings. The only exception was the closure of the Rivers Crossing mental retardation facility in Athens in State Fiscal year 1996 which allowed the closure of 37 beds and concurrent placement of 37 consumers in the community.

In 1992, five hundred twenty-three (523) individuals currently residing in state mental retardation institutions/units were identified as meeting criteria for community placement. In addition, currently 189 individuals are on Waiting Lists for institutional services and 1,995 individuals are on Waiting Lists for community-based services. (See Attachment 5, Mental Retardation Waiting Lists) Every year approximately 400 individuals graduate from special education classes in the Georgia school system and are in need of services. The crisis of capacity to meet these needs grows each year.

* * *

Expanding Georgia's Community Services

Brook Run Closure

[Logo] DHR

Georgia Department of Human Resources -
Division of Mental Health Mental Retardation and
Substance Abuse
July, 1997

Expanding Georgia's Community Mental Retardation Services A plan to close Brook Run

The Georgia Department of Human Resources (DHR) will expand community mental retardation services by closing Brook Run, a state institution in DeKalb County, state and Medicaid funds to serve the residents in new community programs, plus more than 200 people from the waiting list.

Brook Run serves 326 people from 37 counties in metro Atlanta and northeast and northwest Georgia. (See Attachment A for number of residents by region.) Most of the residents need 24-hour supervision and assistance with daily living but do not have special health care problems. More than 100 residents take part in workshops on campus: 22 hold regular jobs through supported employment; and 39 residents attend school, including 19 who go to schools off campus. Sixty-eight residents currently receive skilled care for their physical disabilities or special medical needs.

This plan describes the steps required to ensure that Brook Run's closure is smooth, that the residents and

others receive the services they need, and that all relocations are done carefully. The time frame for each activity may be found in Attachment B.

Briefly, Brook Run's closure means:

- 326 Brook Run residents will have an opportunity to move to new community services under the watchful eye of the state, advocates and a special oversight committee.
- Family members will be involved in planning their relative's new placement, and they will participate in a monitoring system to ensure their safety and well being.
- 206 people from the waiting list will receive community based services – 156 people in residential and day services and 50 people in supported employment.
- Brook Run residents who are medically complex and want continued hospital care will be moved to an upgraded unit at Georgia Regional Hospital in Atlanta or to another state operated facility closer to home.
- Residents from Georgia's other mental retardation facilities will have a chance for community services in place of Brook Run residents who choose continued hospital care.
- Temporary and immediate care beds will be maintained in the Atlanta area to help families during a crisis.
- Dental services will be maintained in the Atlanta area for those with critical needs

who cannot be served by community dentists.

- A monitoring system for community services will be strengthened.
- The costs of maintaining an aging facility will be eliminated.
- Brook Run's 489 classified employees will be considered for job openings at two state institutions in Atlanta. Many may find jobs in the new community services. Employees will be offered training to become certified nursing assistants, an occupation in high demand in metro Atlanta.
- The property will be turned over to the State Properties Commission for disposition after the last resident leaves.

Why close an institution?

At public forums and other meetings across the state, citizens with mental retardation, their families and other advocates have urged DHR to move away from institutional care toward more progressive and individualized services that allow people with mental retardation to become as independent as possible and to live more normal lives in their home communities. Advocates statewide support this shift for both humane and economic reasons.

Quality of care – More than 50 studies nationwide and our own experience in Georgia show that people with mental retardation who move from institutions to community services make dramatic gains. They learn a variety of daily living skills, have fewer behavior problems,

usually have more contact with their families and are more satisfied. Two years ago, DHR moved 64 people with severe and profound mental retardation from state institutions to community programs under the SH/PF class action law suit. Half of the residents could not walk: a large number had both mental illness and mental retardation. Only one person has been readmitted to a mental retardation institution. Most have made progress beyond families' and staffs' expectations.

Growing waiting lists – Georgia has nearly 2,000 people on waiting lists for community services, and the number grows by about 400 people each year. Only 189 families have requested institutional services. Many of the people on waiting lists are just as disabled as the residents at Brook Run. Some parents are elderly and growing frail. They are desperate to know what will happen to their grown children when they are no longer able to care for them. New state funding is not available to develop the services these families need. DHR must use existing dollars to expand community services.

The real possibility of litigation – If we do not begin to serve people on the waiting lists, Georgia will likely face a class-action law suit.

Georgia's lack of progress – Across the country, the number of people with mental retardation in institutions has dropped from 194,650 people in 1967 to 65,735 residents in 1994. Five states no longer operate any public institutions. In the past 20 years, the number of people receiving community residential services increased six fold. Georgia ranks near the bottom – 48th among states –

when it comes to funding services for people with mental retardation in the community.

The high cost of institutional care – The average cost to serve someone at Brook Run is \$267 per day; the cost in the community under the Home and Community-Based Waiver ranges from \$106 to \$181 per day for residential, day training and a range of support services. It costs more than \$3.3 million each year just to maintain Brook Run's buildings. The hospital residents who moved to the community two years ago under the SH/PF law suit cost, on the average, \$24,000 per person, per year less than it would cost to serve them at Brook Run. They are receiving the full range of services they need, and they are just as disabled as the Brook Run residents. Only one person has returned to an institution.

DHR's obligation to close hospital beds – Under the current "Home and Community Based Medicaid Waiver," DHR agreed to close 1,000 hospital beds; we have closed only 147. To continue using Medicaid funding for new community mental retardation services, we must close hospital beds and move the Medicaid money from the institution. Closing beds one at a time without closing a complete unit or hospital is not economical, because the infrastructure must be maintained for the residents who remain. When the same costs are spread among fewer residents, the per person costs increase dramatically.

The FY '98 Budget Redirect – As part of the Governor's plan to have state agencies "redirect existing state funds to develop or expand priority services, DHR is proposing to redirect over \$7 million from mental retardation institutions to community mental retardation services. To

achieve this funding, more than 300 hospital beds must close, and the closing must be consolidated in one institution.

Why close Brook Run?

Brook Run is the right size to produce the funding needed, and it is a manageable size to close in the time frame required. It is the smaller of the two state institutions that serve only people with mental retardation. Gracewood State School and Hospital in Augusta has over 600 residents and would be more difficult to close. Four state psychiatric hospitals also have mental retardation units. Closing a unit would not produce the same funding because many of the hospital's fixed costs would continue.

A second reason for choosing Brook Run is its location. Metro Atlanta has more available housing to lease for residents, most of whom come from the Atlanta area. Atlanta has more job opportunities for staff, including vacancies at two other state facilities in DeKalb County. Also, many of the new community programs will be in the metro area. Closing Brook Run in Atlanta will not have the same economic impact as closing an institution in a small community.

Other options for Brook Run were considered, but were not feasible. The most stringent reduction in operating costs would save only 10 percent of the budget and would not produce the amount needed for the FY '98 Budget Redirect. Eighty-three percent of Brook Run's

budget is personnel costs. Significant reductions in personnel would jeopardize patient care, federal certification and the funds that are tied to it.

Privatizing Brook Run is not the answer. The legislation passed in 1993 to reform the public mental health, mental retardation and substance abuse service system contained some safeguards for current employees to prevent them from losing their jobs as a result of privatization. Again, because 83 percent of Brook Run's cost is personnel, a private company would not be able to save money as long as it must keep the same staff at the same salaries.

Quality of care had nothing to do with choosing Brook Run for closure. Brook Run recently received Accreditation with Commendation from the Joint Commission on Accreditation of Healthcare Organizations. All of Georgia's state institutions received JCAHO accreditation during the same survey period.

The decision on Brook Run is more far reaching than the facility's future. It is a policy decision about the future of Georgia's public mental retardation services. Rather than relying on costly, "one size fits all" institutional care, we will move forward by expanding more individualized community services that offer a better quality of life.

* * *

Thursday, Nov. 20, 1997, p. F3,
The Atlanta Journal/The Atlanta Constitution

State urging leaner mental hospitals

Money troubles: Cost-cutting effort leads to proposed incentive for reducing in-patient care at state's psychiatric facilities.

By Christy Oglesby

STAFF WRITER

State officials are proposing a financial incentive to try to get more people out of state-run psychiatric hospitals and into community-based programs.

Under the proposal, the regional medical boards that govern the state's psychiatric hospitals will be allowed to spend more money on community-based programs if they reduce the amount of time patients spend in hospitals.

The budgeting adjustment is the latest development in an effort that began four years ago to cut costs by downsizing and consolidating hospital services.

Board members of the Department of Human Resources will vote next month on the proposal and other recommendations to continue streamlining.

"We need to promote the downsizing for two reasons," said Eddie Roland, director of the division of Mental Health, Mental Retardation and Substance Abuse of DHR. "First is the cost of in-patient care and the overhead. The second reason is we find for most consumers that they do far better and are able to be more productive" in community settings.

Currently, regional medical boards are permitted to spend 10 percent of their money on community-based

psychiatric services provided in counseling offices, group homes and other arrangements. Under the new proposal, boards would be able to spend 15 percent of their budgets on such services. As a result of spending less on hospital care, the boards would have more money to spend on outpatient services.

Mental health advocates have supported the state's effort to move people out of institutions and place them in living conditions that teach independence.

Since the mental health division started its downsizing plan in 1993, hospital use has dropped by 27.8 percent, or 580 beds, and \$29.5 million saved as a result has gone into community services.

Additionally, two mental retardation facilities – Brook Run in Dunwoody and River's Crossing in Athens – have closed. In the spring, DHR will ask legislators to approve the closure of the Georgia Mental Health Institute, a psychiatric hospital on Briarcliff Road.

Hospital consolidation plans in Augusta and Middle Georgia are under way. Mental health hospitals in Mill-
edgeville, Savannah and Columbus will share one chief operating officer as well as some departments such as personnel, purchasing and billing. As the shrinking continues, the board must deal with the politics of economics and employment, Roland said.

Georgia employs about 9,000 people at its remaining eight mental health hospitals and one mental retardation facility.

UNITED STATES DISTRICT COURT
NORTHERN DISTRICT OF GEORGIA
ATLANTA DIVISION

[Caption Omitted In Printing]

ORDER

(Filed Oct. 20, 1998)

This action is before the Court on plaintiffs' motion in limine on remand. For the following reasons, the Court grants the motion.

The court of appeals remanded this case for further proceedings on the issue of whether requiring the State to make additional expenditures in order to provide plaintiffs L.C. and E.W. with integrated services "would be so unreasonable given the demands of the State's mental health budget that it would fundamentally alter the service it provides." *L.C. by Zimring v. Olmstead*, 138 F.3d 893, 905 (11th Cir. 1998). A hearing on this issue is scheduled for October 29, 1998.

Plaintiffs seek an order *in limine* limiting the evidence at the hearing to the impact of additional expenditures, if any, required to serve the two plaintiffs in this case and excluding evidence regarding the possible future impact of the court of appeals' decision on other individuals. Defendants, on the other hand, seek to adduce evidence at the hearing as to the State's overall care-delivery system for all mentally disabled persons. The Court concludes that only evidence regarding additional expenditures for the two plaintiffs in this action is relevant to the issue on remand.

The court of appeals' decision is quite clear that the issue to be decided on remand relates to the provision of integrated services only to L.C. and E.W. *L.C. by Zimring v. Olmstead*, 138 F.3d at 905 ("The district court did not consider whether *treating* L.C. and E.W. would require additional expenditures and if so, whether the State had met its burden of proving that those expenditures were unreasonable in light of the State's mental health budget") (emphasis supplied)). The court of appeals specifically noted that "this case is not a class action, but a challenge brought on behalf of two individual plaintiffs. Our holding is not meant to resolve the more difficult questions of fundamental alteration that might be present in a class action suit seeking deinstitutionalization of a state hospital." *Id.* at 905 n.10.

Thus, the only issue before the Court on remand is whether, given the demands of the State's mental health budget, any additional expenditures required to treat L.C. and E.W. in community-based programs would be so unreasonable as to fundamentally alter the service the State provided. Evidence regarding the impact the decision in this case may have beyond L.C. and E.W. is irrelevant to this issue.

Accordingly, the Court GRANTS plaintiffs' motion in limine on remand [#104-1].

IT IS SO ORDERED, this 19th day of October, 1998.

/s/ Marvin H. Shoob
Marvin H. Shoob, Senior Judge
United States District Court
Northern District of Georgia

Opening the Gateway to the Future

[Pictures Omitted In Printing]

1997 ANNUAL REPORT

Georgia Department of Human Resources
Division of Mental Health, Mental Retardation and Substance Abuse

AN OPEN LETTER

By LARRY FRICKS

* * *

Governments that muzzle the empowerment of individuals and natural supports of communities are destined to fail. And among society's most muzzled populations has been people with disabilities. Since the Georgia State Lunatic Asylum opened in 1843, and all across this country, we built a system of services focusing on people's disability rather than their potential. Stigma forced that national philosophy. Thus, we were locked away.

* * *

[Pictures Omitted In Printing]

DOING FOR THEMSELVES

From top to bottom, Christine Gomez, Randy Jones and Nydia Brumfield are Georgians "doing for themselves" with the help of services like job placement, supported living, and a drug treatment program.

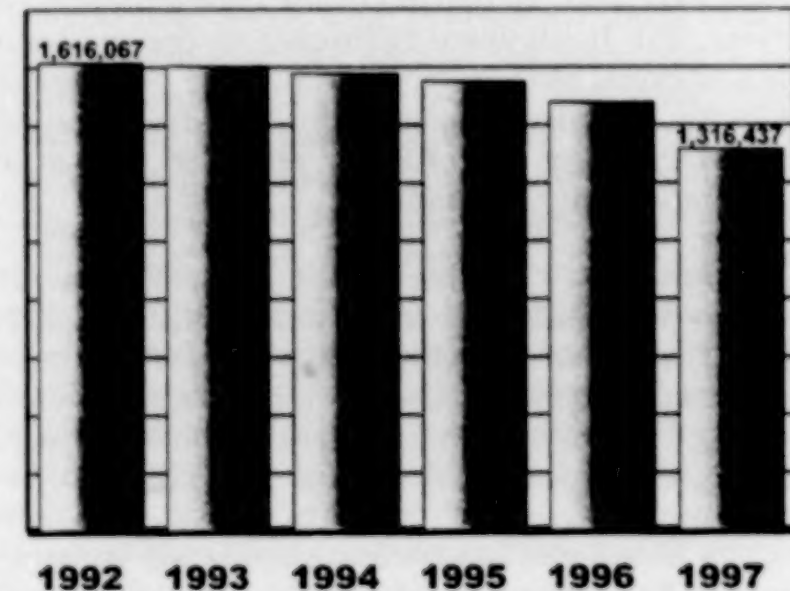
Reduced Hospital Use: Expanding Community Services by "Redirecting the Dollars"

The impact of the MHMRSA Reform, a need to serve more with less, an increasing demand for service, the

availability of new more effective psychotropic medications, and new approaches to community treatment and support put the Division on a course of action that supported hundreds of people to live more successfully in community settings and reduce the need for hospital services. The reduction in hospital services resulted in a significant increase in community services.

All State Hospitals Days of Hospital Care

(For A 19% Reduction Over Period)



1997 Highlights and Accomplishments

- Fiscal year 1997 was the first year that funds were transferred using the hospital allocation formula. The formula is a method by which regions with reduced hospital use can transfer funds from hospitals to community services.
- Fiscal year 1997 was also the first year of the Governor's budget redirection effort which allows funds to be transferred or "redirected" to reflect new priorities

and changing needs. The process was consistent and supportive of existing strategic plans to move hospital funds to community services.

- Hospital admissions declined by 30 percent, which made possible the elimination of 500 beds system-wide.
- There has been a dramatic decrease in hospital services for children and adolescents with severe emotional disturbance (SED). Since Fiscal year 1992 the days of hospital care have declined 42 percent. In Fiscal year 1997, 50 percent of the inpatient beds were closed. The funds were redirected to the community for additional SED services at only half of the needed capacity. DHR has requested that services be funded statewide by the end of Fiscal year 1999, still at only half the capacity needed.
- There has been a similar decline in inpatient hospital services for adults with chronic mental illness (CMI). Since Fiscal year 1992 the days of hospital care have decreased 26 percent from 751,047 days to 556,355. Almost \$30 million has been redirected from the hospital system to the community. The Division has a multi-year plan to add funding for specialized community based services for this population in targeted areas of the state each year. DHR has requested that services be funded statewide by the end of Fiscal year 1999.
- During 1996, the alcohol and drug unit at Georgia Mental Health Institute (GMHI) was closed. Funding for this unit was redirected to community substance abuse services in the four regions of the state that are served by GMHI. With the closing of this unit, the MHMRSA system no longer operates hospital based units for substance abuse services.

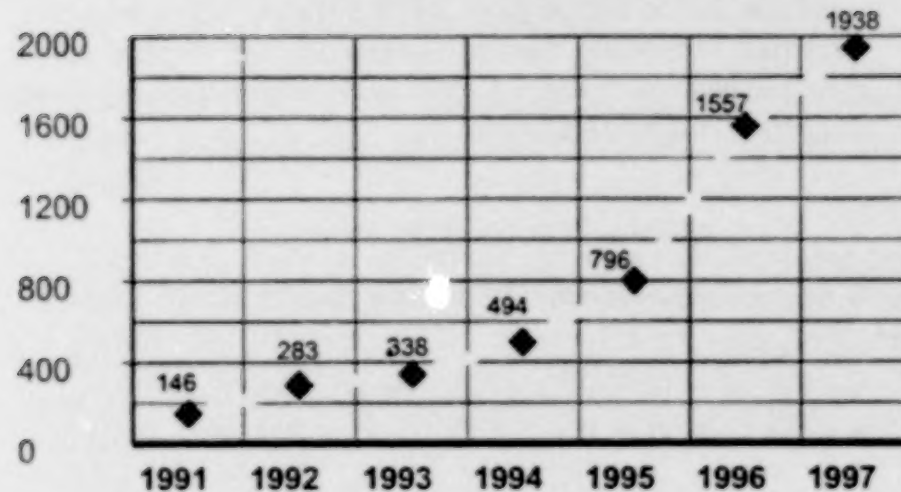
- Rivers Crossing, a 37 bed facility in Athens, was the first mental retardation institution to be closed in Georgia. Since Fiscal year 1994 various units in other facilities including Southwestern State Hospital have also closed. A total of 147 institutional beds were closed in these facilities.

[Picture Omitted In Printing]

Brook Run mental retardation facility, below, closed in 1997.

- The closure of Brook Run, left, a large mental retardation facility in Atlanta, transferred 326 persons with mental retardation from institutional beds to community placements. As part of the Governor's budget redirections, \$15 million will be redirected from the institution to expand community services. An additional 206 people who are on waiting lists or graduating from special education classes will be able to receive community services.
- The Medicaid Home and Community Based Waiver has funded many more people with mental retardation to live in the community. The waiver allows the use of federal Medicaid funds in the community instead of institutions. It also "stretches" state dollars; for every \$1 of state funds, Medicaid pays almost \$2 toward the cost of services. A statewide agreement among regions allows these funds to follow the consumer anywhere in the state. In Fiscal year 1997, the waiver served 1,938 people statewide.

Total Consumers:
Mental Retardation Waiver Program



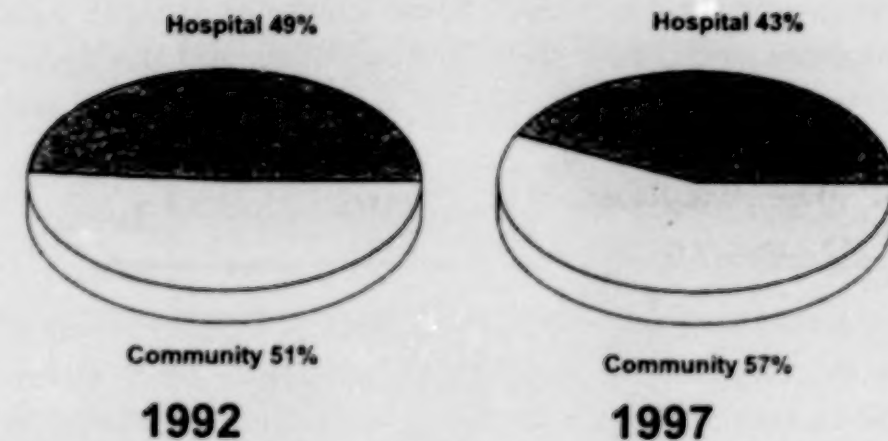
Trends

The Division's Reform has opened the door for reducing dependence on hospital services by enhancing community service. Funds now follow the consumer, and community services continue to grow as the need for hospital services decreases. This trend is expected to continue. Note the relationship between hospital use reduction and the growth of community services as well as anticipated changes highlighted in this section.

[Picture Omitted In Printing]

Melissa Holmes enjoys cooking in her supportive living apartment.

Where Clients Are Served
By Expenditure, 1992 vs. 1997



Future Directions

As consumers are served closer to home by enhanced community services, there will be a decreased need for hospital beds for all MHMRSA disabilities. The need for fewer hospital beds will result in a smaller hospital system. Plans to consolidate administrative and patient support services were developed for Atlanta Regional and Georgia Mental Health Institute, Augusta Regional and Gracewood, as well as Central State Hospital, West Central Georgia Regional Hospital, and Savannah Regional Hospital. The DHR Board has proposed the closure of the first mental health hospital, Georgia Mental Health Institute in Atlanta. Plans are underway to evaluate and plan for the future capacity, location and cost of state hospital services.

The state hospitals that remain open will have new or additional roles in providing services to consumers. State hospitals are already going beyond their walls to set up assertive community treatment teams and other services to help people live in the community and avoid repeated

hospitalizations. In order to compete in the new environment, hospitals are also implementing "Best Clinical and Administrative Practices." Some examples include new processes to measure treatment outcomes and the development of a consistent set of service descriptions and costs.

Community Living

Reduction in the use of hospital beds is a direct result of the development of supported community alternatives. This is especially true for individuals who have lived in hospitals for many years and now have the opportunity to live in the community. The growth of residential services in the community as well as the range of service options is highlighted in this section.

[Picture Omitted In Printing]

Home manager Phyllis Turner, left, reviews the household plans with Melissa Holmes.

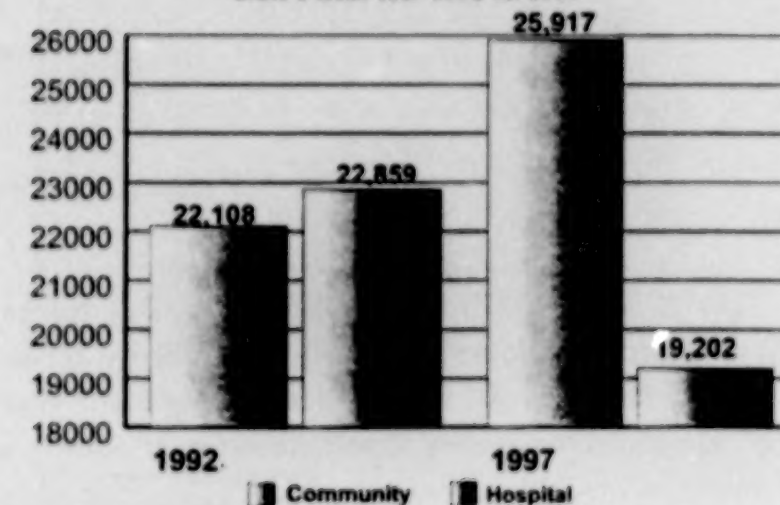
1997 Highlights and Accomplishments

- In Fiscal year 1997, 35 percent more consumers received residential services in community settings than in hospitals. In Fiscal year 1992 approximately the same number of consumers resided in the hospitals as in the community.
- Regional boards are beginning to fund a new generation of services including mobile crisis services, assertive community treatment teams, wraparound services for children, family support and respite services, new more effective medications, supported

employment and supported housing. There has also been an increase in community based emergency receiving facilities.

Total Served: Community Residential vs. Hospital Services

State Fiscal Year 1992 vs. 1997



[Picture Omitted In Printing]

Betsy Goodrich is living in her community and enjoys the pace of the workplace.

- That all people should be supported to live in the community has long been a value prized by consumers, direct service staff and advocates. During the system reform, consumers demanded and professionals agreed that we need to learn more about how to support people and that their potential for independence/self-sufficiency has far exceeded earlier assumptions.

A Call For Resolve:

Fulfilling Our Promise

to Consumers, Families, and Communities

Final Report of

The state commission on
Mental Health, Mental Retardation,
and Substance Abuse Service Delivery

Promising Trends

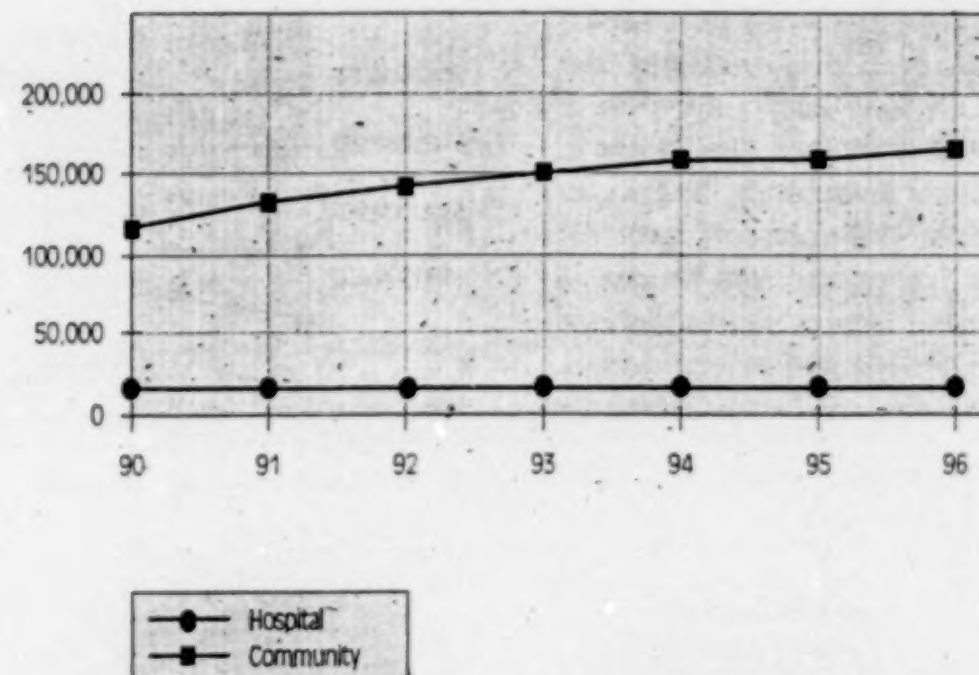
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Note: This is an unduplicated count. Hospital refers to "Hospital Residential Services" and Community refers to "Community Services All Modalities". "Medicaid Waiver Service" accounts for a very small number of clients and is not included in this chart.

This chart shows a flat Hospital line over the 7-year period at around 24,000 clients. Community Services steadily climb during this same time period, reaching more than 150,000 clients served in 1994 and continues upward to current high of 165,239. Thus, the overall growth in clients served has occurred in Community Programs and not in Hospitals.

CHART 1

Number of Clients in Hospitals and Community Services: SFY 1990-96

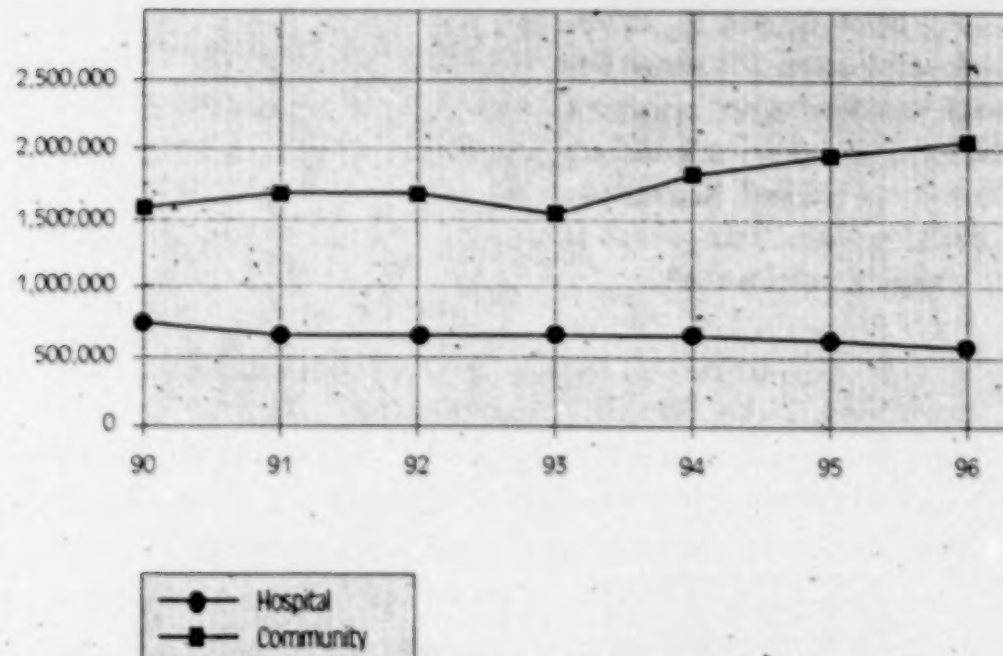


Note: Hospital refers to "Hospital Residential DACE" and Community refers to "Community Residential DACE".

This chart shows a decline in Hospital DACE over the 7-year period from 727,146 to 551,819. Community DACE is relatively flat for the first few years, then beginning in 1994, steadily increases reaching over 2 million in 1996. These data demonstrate that the growth in DACE is occurring in community-based programs and not in hospital settings.

CHART 2

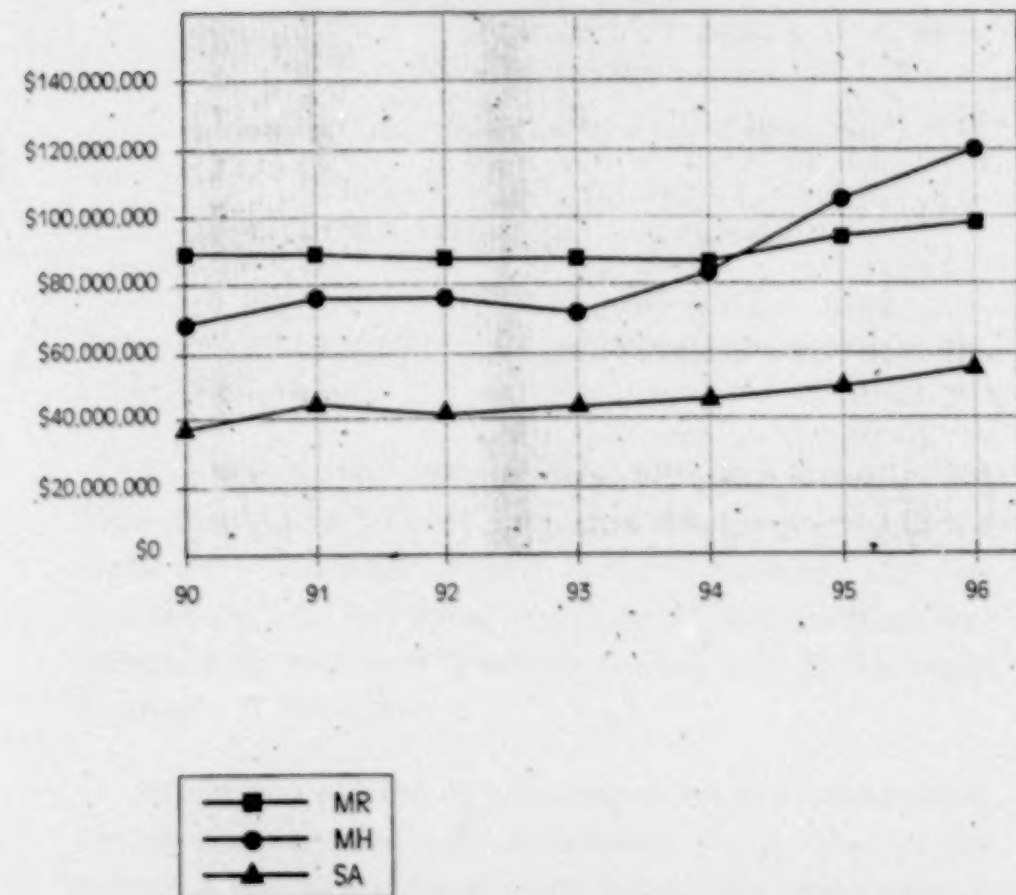
Number of Days Active Client Enrollment (DACE) in Hospital and Community Residential Services: SFY 1990-96



Note: Includes federal and state funds received by Georgia Department of Human Resources (DHR). This chart does not include Department of Medical Assistance state and federal funds. MH refers to "Mental Health", MR refers to "Mental Retardation", and SA refers to "Substance Abuse". SFY 1997 is not included because of transfer of state funds to Medicaid for the MR waiver conversions. DMA state and federal dollars are not reflected in this chart.

CHART 3

DHR Funds Available for Community Programs:



This chart shows fund availability to be fairly flat from SFY 1990 through 1993, and then increasing steadily from SFY 1993 through 1996. Mental Health, in particular, has a substantial increase beginning in 1994. Substance Abuse experiences an infusion of funds in SFY 1991; bring it above \$40 million and then remains steadily until 1995 when it raises to \$50 million and reaches nearly \$55 million in 1996. Growth in funding for Mental Retardation has also occurred through leveraging state dollars

through the Mental Retardation Waiver Program. This growth is not illustrated in this chart.

* * *

Hospital Resources

Allocation Task Force

FINAL REPORT

November 1997

Georgia Department of Human Resources

*Division of Mental Health,
Mental Retardation and Substance Abuse*

* * *

**SUMMARY – IMPACT OF HOSPITAL FORMULA ON
PURPOSES 1 AND 2**

The implementation of the hospital formula did indeed have a significant impact on the downsizing of the eight state hospitals, as well as fostering more effective application of CMI funding. Hospital downsizing was sufficient to seriously consider closing one of the eight hospitals at this time.

While downsizing of public agencies or institutions is always accompanied with difficulties, the process for the hospitals was relatively systematic and free from crisis. A unique feature of the formula required each region to purchase hospital inpatient services at 90% of the magnitude experienced two fiscal years earlier (unless its Fair Share was less than this amount), whether the region needed this level of service or not. If a region's Fair Share is less than the 90% of its hospital budget, it is required to apply the entire Fair Share to the purchase of hospital services. Thus, the hospitals had only to reduce operations of the applicable adult MH/SA cost centers for each of the two fiscal years that the formula has been in effect

at a rate that is approximately ten percent of the operational level experienced two fiscal years previously. Amazingly, only one hospital had to exercise a reduction-in-force (RIF) during FY 1997 and one hospital in FY 1998. The other hospitals apparently were able to make the necessary adjustments through employee attrition and other organizational modifications.

This reduced dependance of the regions on hospital inpatient services could not have been realized if the regions had not been provided significant control over the funds for the impacted adult MH/SA hospital cost centers. Thus, Purpose 1 – shift of control of hospital funds from hospitals to the regional boards – must be viewed as successful.

* * *

THE PATH AHEAD

**A Two Year Plan
of the
Department of Human Resources
Division of Mental Health,
Mental Retardation
and Substance Abuse**

June 1997

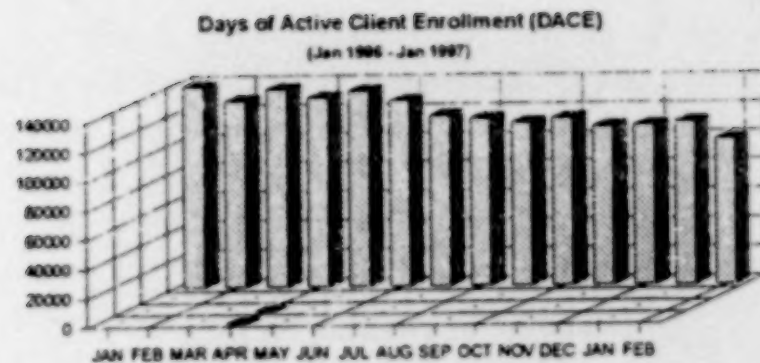
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Too often they are inappropriately housed in state hospitals, jails, nursing homes or at home with a family that is financially and emotionally exhausted. Some end up on the street. Approximately 264,000 Georgians suffer from serious mental illnesses such as schizophrenia, major depression and manic depression. Many go unserved until a major crisis occurs. Costly state hospital care is often the result when community services do not exist.

* * *

Reducing Hospital Use

- A comparison of days of active client enrollment (DACE) in the hospitals from January 1996 to January 1997 reveals declining hospital use. This comparison shows a 20 percent decrease in the use of hospitals.



- Persons with mental retardation are moving from mental retardation institutions back to their communities. Since the passage of HB 100, 147 institutional beds for persons with mental retardation have closed.

* * *

IN THE UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF GEORGIA
ATLANTA DIVISION

[Caption Omitted In Printing]

AFFIDAVIT OF CARROLL D. BENSON

* * *

2.

I am the Director of the Monitoring and Evaluation Section of the Division of Mental Health, Mental Retardation and Substance Abuse ("MHMRSA") of the Georgia Department of Human Resources ("DHR"). I manage the Division's program evaluation process, performance evaluation measurement, provider certification, legal and risk management, consumer rights, consumer advocacy, licensure activities, the Behavioral Health Data Center, and investigations. I have a Masters of Education degree in Rehabilitation Counseling.

3.

In my position as Director of the Monitoring and Evaluation Section, I was familiar with the cases of L.C. and E.W., and, ultimately, their placement in the community. I have also read the order of the Court of Appeals in this case, as well as the First Affidavit of Carl E. Roland. I believe that the order is very ambiguous in some regards. However, it suggests an approach to the provision of services for the mentally disabled that is fundamentally different from the provision of these services in Georgia today.

4.

First, the order seems to rely entirely on the Department of Justice's current interpretation of the "Integration Regulation" as the one-and-only principle that should guide Georgia's programs. This ignores Georgia's system of governance that has been carefully developed since the reform legislation of 1993.

5.

Prior to 1993, the governance, funding, and management of the system created a service delivery system that was called "a patchwork of programs stitched together over time" that has "left gaps and shortcomings in the system." (See Attachment A, which is a true and correct copy of the Report of the State Commission on Mental Health, Mental Retardation, and Substance Abuse Services Delivery, Atlanta, Georgia, 12-1-92, p. 1.)

6.

The State Commission on Mental Health, Mental Retardation, and Substance Abuse Services Delivery (the "Commission") was established for the purpose of "developing a comprehensive plan for an improved services delivery system for the treatment and habilitation of people with mental illness, mental retardation and substance abuse problems. . . ." (Attachment A, Report of State Commission, p. 3).

7.

The Commission developed a set of guiding principles to be used as they talked about system change and design. These principles have become a way to organize the implementation of the reform, and they still guide our ongoing work.

8.

I believe that the Court of Appeals' order fundamentally alters these principles. These principles are listed on pages 11 and 12 of the Report. Three of the key principles which appear to be in most conflict with the order are as follows:

9.

CONSUMER CHOICE. The Commission's first principle is consumer choice: "Consumers and families shall have choices about who the service providers are by having input in planning the service system, and which services will be provided by being involved in the development of their individualized service plans." The Court of Appeals' order, however, requires the "most integrated setting appropriate" *according to the professionals*. The order appears to be in direct conflict with the Commission's principle.

There are times when the consumer's choice is not the community, but a facility. For example, when Brook Run, an Intermediate Care Facility for the Mentally Retarded ("ICF-MR") was closed in December 1997, over

a hundred individuals chose to continue to receive services in an ICF-MR rather than in a community placement.

Arguably, if the Court of Appeals' standard of requiring the most integrated setting had been followed, it would not have been possible to give these consumers a choice, since many of them "could" have been placed in the community with adequate support.

10.

MOST IN NEED. The Commission Report adopted a "most in need" principle to guide the allocation of scarce resources: "Given that there will never be sufficient resources to meet the total need for people with mental illness, mental retardation and substance abuse problems, public funds shall be allocated to ensure the needs of consumers who are most in need are met at the appropriate service levels."

For example, a Region may decide that a person in the community who is receiving no services and whose parents have become ill is "most in need," compared to another person in an institution who is receiving services. The Court of Appeals' order appears to severely limit or destroy a Region's ability to make this type of allocation, since the order may be interpreted to require the State to serve the institutionalized person first.

11.

QUALITY OF SERVICE. Another of the Commission's principles is that the "system shall be designed to

provide the highest quality services utilizing flexibility in funds and incentives which reinforce quality and efficiency." However, the Court of Appeals' order does not seem to provide such flexibility.

First, the order may require the "most integrated" treatment in lieu of the "best quality" treatment. There are times when a consumer can be appropriately treated in the community, but the treatment that can be provided in the institution is of better quality.

Also, "flexibility in funds and incentives which reinforce quality and efficiency" allow the cost to be considered. Although it is *generally* true that it is cheaper to treat a person in the community rather than in a facility, this is by no means always the case. It will often be significantly cheaper to serve a medically fragile person or a person with complex behavior in a facility rather than in a community.

12.

These are three of the most important principles of the Commission that conflict with the order. I believe that the entire approach of the Court of Appeals is fundamentally different from Georgia's approach.

13.

It should be noted that the Commission's recommendations, published in December 1992, were profoundly and effectively supported in the State. In April 1993, the Georgia legislature passed a sweeping reform of the MHMRSA service system. House Bill 100 created the

framework for a new public service system with more local planning and decision-making from consumers and family members. (See Attachment B, which is a true and correct copy of the 1997 Annual Report, Georgia Department of Human Resources, Division of MHMRSA, "Reform of the System," p. 7; Attachment C, a true and correct copy of the Final Report of the State Commission).

14.

One result of the reform has been the planned and systematic reduction in hospital services. Hospital admissions declined by 30 percent. The patient-days of hospital care declined by 19 percent. Five hundred hospital beds were eliminated system-wide. (Attachment B, 1997 Annual Report, p. 13.) Brook Run was closed in December 1997, and the Georgia Mental Health Institute was closed June 30, 1998.

15.

At the same time, the number of persons who received community residential service has increased, from 22,108 in 1992, to 25,917 in 1997. (Attachment B, 1997 Annual Report, p. 17). The number of persons funded on a Medicaid Home and Community Based Waiver has increased from 283 in 1992, to 1,938 in 1997. (Attachment B, 1997 Annual Report, p. 15).

16.

The percentage of community funding has changed from 51% of the total of community and hospital funding

in 1992, to 57% in 1997. (Attachment B, 1997 Annual Report, p. 16).

17.

It was through the reform described above that it was possible to place L.C. and E.W. in the community, as funding became available and, in regard to E.W., after her serious medical condition was surgically and medically treated. Fiscal incentives and management have been key in accomplishing these results. (See Attachment D, a true and correct copy of the Hospital Resources Allocation Task Force: Final Report, November 1997; see also, Attachment E, a true and correct copy of the 1997 Two Year Plan).

18.

The Court of Appeals' order states that the State must spend additional funds to place L.C. and E.W. in the community unless it would be so unreasonable that it would fundamentally alter the services the State provides. *L.C. and E.W. v. Olmstead*, 138 F.3d 893, 905 (11th Cir. 1998). Of course, it is unlikely that services for any two individuals will cause a fundamental alteration, given that the State provided residential services for over 45,000 persons in 1997. (Attachment B, 1997 Annual Report, p. 17). However, the provision of services in the manner envisioned by the Court of Appeals *would* be a fundamental alteration, and it ultimately would cause a fundamental alteration in Georgia's programs and services.

19.

It is impossible to calculate how many consumers "could" be served in the community, according to the experts, given unlimited funding to provide adequate support in the community. However, there are approximately 1900 persons on the waiting list for services, and provision of these services would be likely to cost \$100,000,000. Some additional numbers of the individuals currently being served in hospitals (potentially all of them, as stated by Mr. Roland in his first affidavit) could also be moved to the community, with the closure of some or all of the State's hospitals and the expenditure of additional funds.

20.

Finally, the Court's Order would interfere with the discretion and authority of the Regional Boards to plan, purchase, and contract for community and hospital services, as was explicitly called for by the State Commission and mandated by the 1993 legislation. The Court's order shifts the locus of control away from the local communities and towards the individual patients' treating professionals alone.

FURTHER AFFIANT SAYETH NOT.

/s/ Carroll D. Benson
CARROLL D. BENSON

Sworn to and subscribed
before me this 29th day
of October, 1998.

/s/ Linda Joyce Parker
NOTARY PUBLIC

My commission expires:

Notary Public, Clayton County, Georgia
My Commission Expires April 7, 2001

DEPOSITION EXCERPTS:

IN THE UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF GEORGIA
ATLANTA DIVISION

L.C., by JONATHAN ZIMRING)
as Guardian Ad Litem & N/F)
vs.)
TOMMY OLMSTEAD,)
Commissioner, et al.)

THE DEPOSITION OF DR. RAMESH N. AMIN.

* * *

DECEMBER 13, 1995.

* * *

[p. 94] Q Yes, but can she make the same degree of progress in the hospital that she can make in the community?

A No, not the same degree.

* * *

THE DEPOSITION OF DR. DILPIKUMAR PATEL.

* * *

DECEMBER 13, 1995.

* * *

[p. 101] Q Okay. So before the mother became an option, you were thinking of - please tell me if I said it right - a 24-hour residential home life and a day program like CFI or perhaps something more intense.

A In combination with other structured placement. If you go with the programming treatment needs, then you have the obstructed placement or the residential. Or if you have alternative to that, if you have a residential treatment program for her that is in your favor.

Q But you never - it is true you were never able to locate this kind of program?

A No.

* * *

[p. 123] Q If there her [sic] been a structured placement, in you [sic] opinion would that have been appropriate at that time, if something had been available?

A Yes.

Q Was it your decision that she be transferred [sic] to Brook Run?

A My decision?

Q Yes.

A No.

Q Do you know who made that decision?

A My opinion, personal opinion, it wasn't me. I am observing what I have stated at that point, patient seems to have need for a place to stay -

Q And is it correct that because there was no community structured place, Brook Run was the only alternative?

A That was my understanding.

* * *

[p. 150] Q January of '94.

A January 4. Okay.

* * *

A Patient seems to be at a functional level and on the date of that visit, does not talk about delusions, though occasionally she is seen as delusional and is able to maintain her NDL's most of the time. Periodically does require reminder. No change in mental status.

Q Okay. Does that reflect your opinion of her at that time?

A Yes.

* * *

[p. 151] Q Is that - again, is that saying that for this particular patient she has basically achieved her level of functioning in that area?

A Yes.

Q Would it be correct to say that at this point, clinically you would want to maintain her at this level, would that be correct?

A Yes.

Q Could she be maintained at this level, in your opinion, in the community, in a structured community setting?

A Yes.

* * *

DEPOSITION OF CHARLES B HOPKINS.

* * *

JANUARY 10, 1996.

* * *

[p. 31] A The legislature can appropriate money directly to the Department of Medical Assistance for the mental retardation waiver, and that is - that happens to some extent every year.

In addition to that, regions - the regions can request that some of their existing dollars be moved - be reduced and moved to the Department of Medical Assistance as match for additional people to go into the waiver.

* * *

DEPOSITION OF TOMMY OLMSTEAD.

* * *

JANUARY 30, 1996

* * *

[p. 51] A My concern as the Commissioner is that they operate and fulfill their mission as efficiently as possible, serving - giving the necessary service to the appropriate patients.

Q Could I interpret that to mean that perhaps they could be reduced in size and then still fulfill that mission?

A Yes, they could be.

* * *

DEPOSITION OF JIMMIE L. PARRISH, JR.

* * *

MARCH 11, 1996.

* * *

[p. 94] Q Okay. Did the team decide to discharge E.W. to a shelter?

A Because she refuses, after refusing treatment or other placement, yes.

* * *

[p. 96] Q You think that was an appropriate decision based on the circumstances at the time to discharge her to a shelter? Is that what you're saying?

A No, I'm not.

Q Then was it an inappropriate decision?

A If we acted on it, I would say yes, it was an inappropriate decision. But we never acted on it, so I can't say it was so inappropriate, because we never made the discharge to the shelter.

Q I'm just asking you whether the decision was appropriate or inappropriate. I understand she was never actually discharge to the shelter. But you did testify that your team made a decision to discharge her to a shelter.

A Uh-huh.

[p. 97] Q Speaking today, in your opinion, was that an inappropriate decision?

A Yes.

* * *

DEPOSITION OF DILIPKUMAR PATEL.

* * *

MARCH 12, 1996.

* * *

[p. 25] Q So based on her choice then, she's appropriate to maintain in the hospital. You also felt that she could have been treated as an outpatient at that point?

A Yes. Personality disorder per se does not require hospitalization because that's a changed long-term pattern of behavior, unless there are crises.

* * *

[p. 26] Q What sort of treatment would have been appropriate for her in the community at this time? Assuming she had chosen to be treated in the community, what sort of treatment would that have required?

A What sort of treatment?

Q Yeah, what sort of treatment and what sort of placement would that have required?

A Same kind of treatment that she would require for change of her behavior in the hospital.

Q And what kind of - what kind of treatment was that?

A Outpatient mental health follow up.

Q Are their providers capable of providing that treatment to her in the community?

A Majority of the personality disorders are treated in the community.

Q Okay. Since she elected to stay in the hospital or since at some point - well, why - what happened to change her mind that she stayed in [p. 27] the hospital?

A I believe Ms. Jamieson had intervened at that time to halt the discharge to the shelter.

* * *

[p. 32] A One thing is that she has personality disorder; which as I said, so much that requires a change from the patient, not so much in terms of effective intervention. And keeping a patient in the hospital to make a change in the personality may not be the best structure to treat. She can still continue to get the treatment and change in the personality as an outpatient.

Q And in some ways is the community a better place for treatment?

A For the change in the personality, I don't see - unless there's a crisis - she requires to be in the hospital. I don't say it's better, but I think it's less restrictive than the hospital.

Q Right. And is that the goal of treatment, to get people into the less restrictive environment?

A Less restrictive, yes.

* * *

Q Coming up to the current time period, [p. 33] do you feel EW could be treated in the community at this point still?

A She has difficulty with physical problems at this time. And if that is addressed, I think she could be treated in the community.

* * *

[p. 75] Q Have you explored any placement options with EW or have you discussed any placement options with her other than personal care homes?

A No, I have not.

Q She has these behavioral problems, and I think that's one of the things that was noted on the master treatment plan was the long-term institutionalization. Would you agree that it's better to address those problems in the community than in the hospital?

A It's a long-term problem. It could be addressed in community. But I don't know whether you can call it addressed better in community. No, I think it can be fully good addressed in either outpatient or inpatient. Preferably, from the cost containment point of view, I think it could be addressed better in the community.

* * *

[p. 76] Q If you were aware of a provider who could meet - who [p. 77] could meet her needs in the community, would you be in favor of placing her in the community?

A Yes; why not?

* * *

DEPOSITION OF DR. GARY DEBACHER.

* * *

MARCH 12, 1996.

* * *

[p. 27] Q Right. What would have been a suitable placement for her in the community?

A Well, I would say - as I said, a group home for upper level mentally retarded people with or without some degree of mental illness, with strong staffing and with available day programs, including you know, some vocational activities, treatment activities if necessary.

* * *

[p. 46] Q If you had a home provider who said they would be willing to take her, do you think it would be a good idea to give her a try in the community?

A You mean a staffed group home or just an individual provider?

Q A staffed group home that can provide the things you indicated a group home should do.

A Sure, yeah.

Q At what point do you think it would have been good to try that?

A Well, as soon as we would have known about such a place and had maybe about a month to prepare to, you know, based on her current situation and let her see the place; let them get to know her; talk about contingencies; trial visit her there for a while; you know, give her some encouragement for doing okay.

Q Okay, so any time with a month lead time or so after that April meeting, if you had known [p. 47] about a placement -

A Not after the April meeting. I think maybe - I think it's conceivable that later on there were times when we could have - with a month's lead time, we could have planned and tried that.

Q By the end of the Summer?

A Yeah.

* * *

DEPOSITION OF

DR. RICHARD L. ELLIOTT, M.D., PH.D.

* * *

APRIL 9, 1996.

* * *

[p. 99] Long hospitalizations, frequent hospitalizations are the wrong kind of treatment for somebody with a borderline personality disorder or with whatever you want to call the [p. 100] kind of behavior problems she had. Because these frequent hospitalizations lead to regression and poor outcome, which is what they're seeing.

* * *

DEPOSITION OF CHARLES WILLIAM BLISS.

* * *

MAY 10, 1996.

* * *

[p. 85] A I don't know. We review the results with E.W. and her mother each time Ms. Ligon and I meet.

Q Mr. Bliss, going back to the point in time which we've discussed when there was an intensive case management meeting for E.W., which was April of '95, do you recall that the P&A complaint involved [p. 86] discharge of her to a shelter?

A Yes.

Q You have a recollection of that?

A Yes.

Q I'm just going to ask you whether you have an opinion about whether that would have been an appropriate discharge?

A I would have had concern that she would have returned to the hospital promptly.

* * *

DEPOSITION OF JOSEPH STEED.

* * *

MAY 23, 1996.

* * *

[p. 93] Q Now, do you think it would ever be appropriate to discharge her to a homeless shelter, to discharge E W to a homeless shelter?

A No.

* * *
